

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03788

CERTIFICATE OF DEATH

03784

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b 5 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 110 CLEARVIEW RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES DANIEL BAER SR.		4. DATE OF DEATH Month Day Year MARCH 24 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/1901
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY UTILITY CO.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN L. BAER		14. MOTHER'S MAIDEN NAME MARY E. CORDERMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-9583	
17. INFORMANT Address HAGERSTOWN MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arterio sclerotic cardiovascular disease DUE TO (c) Arterio sclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 7 days 3 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 Mar 1962 to 24 Mar 1962 , that (I) (we) last saw the deceased alive on 23 Mar 1962 , and that death occurred on 13 Apr 1962 , from the causes and on the date stated above.			
22a. SIGNATURE F.F. Lusby		22b. DATE SIGNED 3/24/62	
22c. PHYSICIAN'S NAME (Type) F.F. Lusby		22d. ADDRESS 2300 Potomac St Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/26/62	
23c. NAME OF CEMETERY OR CREMATORY BROADFORDING CH		23d. LOCATION (City, town or county) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W.J. Normant		25a. RECEIVED BY REGISTRAR DATE MAR 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Knease			

1852

2276

(M)

1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the deceased should be placed in a refrigerator or other suitable place. The certificate should be executed by the medical examiner or a deputy medical examiner. If the medical examiner is not available, the certificate may be executed by a physician, dentist, or other qualified person. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5, and the body of the deceased. The certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM E
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03785

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb 10 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 15 S. POTOMAC ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JACOB HENRY BAKER				4. DATE OF DEATH Month Day Year MARCH 1 19 62			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/22/1886	
9. AGE (In years last birthday) 75 Yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER				10b. KIND OF BUSINESS OR INDUSTRY FRUIT FARM		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOSEPH BAKER				14. MOTHER'S MAIDEN NAME MARY KING			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES W.W.#1				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. THEODORE BROWN WILLIAMSPORT MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X cerebral vascular hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) gen. arteriosclerosis & hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard N. Weeks, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Howard N. Weeks, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/5/62			
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEM.				22d. LOCATION (City, town, or country) (State) ARLINGTON VA.			
23. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR W. J. Norment			
				24b. REGISTRAR'S SIGNATURE Arthur S. Haines			

DATE SIGNED
3/3/62

08730

08730

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03786

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN b

PLACE OF EMPLOYMENT

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

ROLL ON TIRE CO. E. WILSON BLVD

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MARYLAND

b. COUNTY

WASHINGTON

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

03 HAGERSTOWN

d. STREET ADDRESS

12 EAST BALTIMORE ST.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

CONARD CLAYTON BEACHLEY

4. DATE OF DEATH

Month Day Year

MARCH 16 1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

FEBRUARY 20 1939

9. AGE (In years last birthday)

23 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TIRE REPAIRMAN - ROLL ON TIRE CO.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BOONSBORO WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

AUSTIN BEACHLEY

14. MOTHER'S MAIDEN NAME

MARIE WAGAMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

YES REG. ARMY

16. SOCIAL SECURITY NO.

215-34-3931

17. INFORMANT

MRS. DAISY BEACHLEY 12 EAST BALTIMORE ST. HAGERSTOWN MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Fracture Of Skull

DU TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DU TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

While inflating tube tire blew up.

20c. TIME OF INJURY

Hour Month, Day, Year

6:25 p.m. 3-16-62 19

20d. INJURY OCCURRED

While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Place of employment.

20f. (City or town)

Hagerstown, Washington, Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

E. W. Ditto Jr.

M.D.

ASSISTANT MEDICAL EXAMINER

☐

DATE SIGNED

3-17-62

EXAMINER'S NAME (Type)

Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

MARCH 19 1962

22c. NAME OF CEMETERY OR CREMATORY

ROSE HILL CEMETERY

22d. LOCATION (City, town, or country)

CLEARSPRING WASH. CO. MD

(State)

23. FUNERAL DIRECTOR

John H. East

ADDRESS

BOONSBORO MD

24a. REC'D BY REGISTRAR

DATE MAR 22 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03787

03791

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Penna. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in lb 1 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS 72 Mt. Vernon Terrace			
3. NAME OF DECEASED (Type or print) First Middle Last Pierce E. Beaver				4. DATE OF DEATH Month Day Year March 3 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1907	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Sales		10b. KIND OF BUSINESS OR INDUSTRY Landis Tool Co.		11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Gross Beaver				14. MOTHER'S MAIDEN NAME Drucie M. King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 321 09 7401		17. INFORMANT Mrs. Pierce E. Beaver		Address Waynesboro, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation (probable)</i> 4-20-62 DUE TO (b) <i>arteriosclerotic (coronary) heart disease</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Ventricular tachycardia intermittently past month</i>						INTERVAL BETWEEN ONSET AND DEATH <i>7 few minutes (found dead) 3 yrs -</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-10, 1961</i> to <i>3-3, 1962</i> ; that (I) (we) last saw the deceased alive on <i>3-3, 1962</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>John H. Hornbaker</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3-4-62</i>	
22c. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER				22d. ADDRESS 154 W. WASHINGTON ST. HAGERSTOWN - MD -			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/62		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City, town or county) (State) Waynesboro, Franklin, Penna.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Gure</i>				ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR DATE MAR 6 '62	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>			

MEDICAL CERTIFICATION

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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03781

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- Handwritten text in the middle: "Handwritten text" (faint)
- Handwritten text at the bottom: "Handwritten text" (faint)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03792

03788

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown Maryland</u> d. STREET ADDRESS <u>222 N. Jonathan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Summer</u> Last <u>Bell Sr.</u>		4. DATE OF DEATH Mar <u>27</u> 19 <u>62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 21 1914</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Bell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Broom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-8963</u>	
17. INFORMANT <u>Mrs Margaret Bell Hagerstown Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic valvular heart disease with congestive failure</u> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 18</u> 19 <u>57</u> to <u>March 27</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>March 26</u> 19 <u>62</u> , and that death occurred at <u>1:45A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u> M.D.		22b. DATE SIGNED <u>3/27/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-1-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr Hagerstown Md</u>		25a. REC'D BY REGISTRAR <u>APR 3 '62</u>	
ADDRESS <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR AIS (4)
15M 7, 61

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03793
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03789
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FURLE HAGERSTOWN</u> c. LENGTH OF STAY IN H <u>3 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>AVALON MANOP</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>1 907 S. POTOMAC ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MISS GEORGE LAPHINE BISTER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 8 1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/8/1882</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIETIPLO FLOEIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FLOEIST SHOP</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM J. BISTER</u>		14. MOTHER'S MAIDEN NAME <u>MARY M. SUMMERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NON</u>	
17. INFORMANT <u>MISS MARY J. BISTER</u>		Address <u>1 907 S. POTOMAC ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Generalized & cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypertensive vascular disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>About 24 hours</u> <u>Unknown</u> <u>Many years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-11, 1952</u> , to <u>3-3, 1962</u> , that (I) (we) last saw the deceased alive on <u>3-3, 1962</u> , and that death occurred at <u>11:52 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hornbaker</u>		22b. DATE SIGNED <u>3-5-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		22d. ADDRESS <u>154 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Hornment</u>		25a. REC'D BY REGISTRAR <u>MAR 12 '62</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>W. J. Hornment</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03794

CERTIFICATE OF DEATH

03790

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. DATE OF DEATH Month March Day 22 Year 1962			
3. NAME OF DECEASED (Type or print) Edgar Brown Brenner			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1889
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY canning factory	
11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Waxler D. Brenner		14. MOTHER'S MAIDEN NAME Carrie Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219005-2869	
17. INFORMANT Address Miss Caroline Brenner, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332 X IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Cerebral Thrombosis DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 Days 1 Wk. 15 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-3 , 19 64 , to 3-22-62 , 19 62 , that (I) (we) last saw the deceased alive on 3-22-1962 , and that death occurred at 6:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles F. Hess</i>		22b. DATE SIGNED 3-23-62	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M. D.		22d. ADDRESS Smithsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Mar. 25, 62	
23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 '62	
25b. REGISTRAR'S SIGNATURE <i>Carroll D. Smith</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, the registrar should be detached from it as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03795

CERTIFICATE OF DEATH

Reg. Dist. No. 03791

1. PLACE OF DEATH a. COUNTY Washington, Ft Ritchie, Cascade MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Louisiana b. COUNTY Baton Rouge	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Ritchie, Maryland		c. LENGTH OF STAY IN 1b Baton Rouge, Louisiana	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Dispensary, Ft Ritchie, Md.,		d. STREET ADDRESS Route #5 Box#32	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HERMAN First Middle Lost BROOKS JR		4. DATE OF DEATH Month Day Year March 16 19 62	
5. SEX Male	6. COLOR OR RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Jun 43
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fix Sta Rec Repmn		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Oscar, Louisiana		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME HERMAN BROOKS SR		14. MOTHER'S MAIDEN NAME MARY G. FEDINAND (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 139-625607	
17. INFORMANT From Army Records By WILLIAM T CUZICK, CAPT., MSC		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 353 Cardiac Arrest following Grand Mal seizure. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10-15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 March 19 62, to 19 , that I last saw the deceased alive on 16 March 19 62, and that death occurred at 9:05 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Patrick J Ferraro capt MC Fort Ritchie, Cascade, Maryland 3/16/62 PHYSICIAN'S NAME (Type) PATRICK J FERRARO, CAPT., MC US ARMY DISPENSARY, FORT RITCHIE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/1962	
22c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		22d. LOCATION (City, town, or county) (State) Glenn, La.	
23. FUNERAL DIRECTOR'S SIGNATURE S. Martin		ADDRESS Waynesboro, Penna.	
24a. REC'D BY REGISTRAR DATE 9 '62		24b. REGISTRAR'S SIGNATURE C. J. ...	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03796 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03792

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY ---		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Washington County Hospital		d. STREET ADDRESS 425 George Street		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Day Brooks		4. DATE OF DEATH March 27 19 62		5. SEX Male	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 May 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired guard		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft		9. AGE (In years last birthday) 69	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Luther Bush Brooks	
14. MOTHER'S MAIDEN NAME Annie Catherine Kees		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW #1		16. SOCIAL SECURITY NO. 235-12-1687A	
17. INFORMANT Mrs. George Beard		18. ADDRESS 627 Faulkner Ave. Martinsburg, W.Va.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Second, third and fourth degree burns involving more than 60% of the body DUE TO more than 60% of the body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO more than 60% of the body PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I e) Paralytic, it was necessary to use cane and crutch to ambulate		INTERVAL BETWEEN ONSET AND DEATH few minutes		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Possibly smoking in bed	
20c. TIME OF INJURY Hour a.m. 1:30AM p.m. Month, Day, Year 3-27-19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town, County) (State) Hagerstown, Washington, Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	
22b. LOCATION (City, town, or country) (State) Martinsburg, Berkeley, W.Va.		22c. DATE THEREOF 3/29/62		22d. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	
23. FUNERAL DIRECTOR Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR MAR 30 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

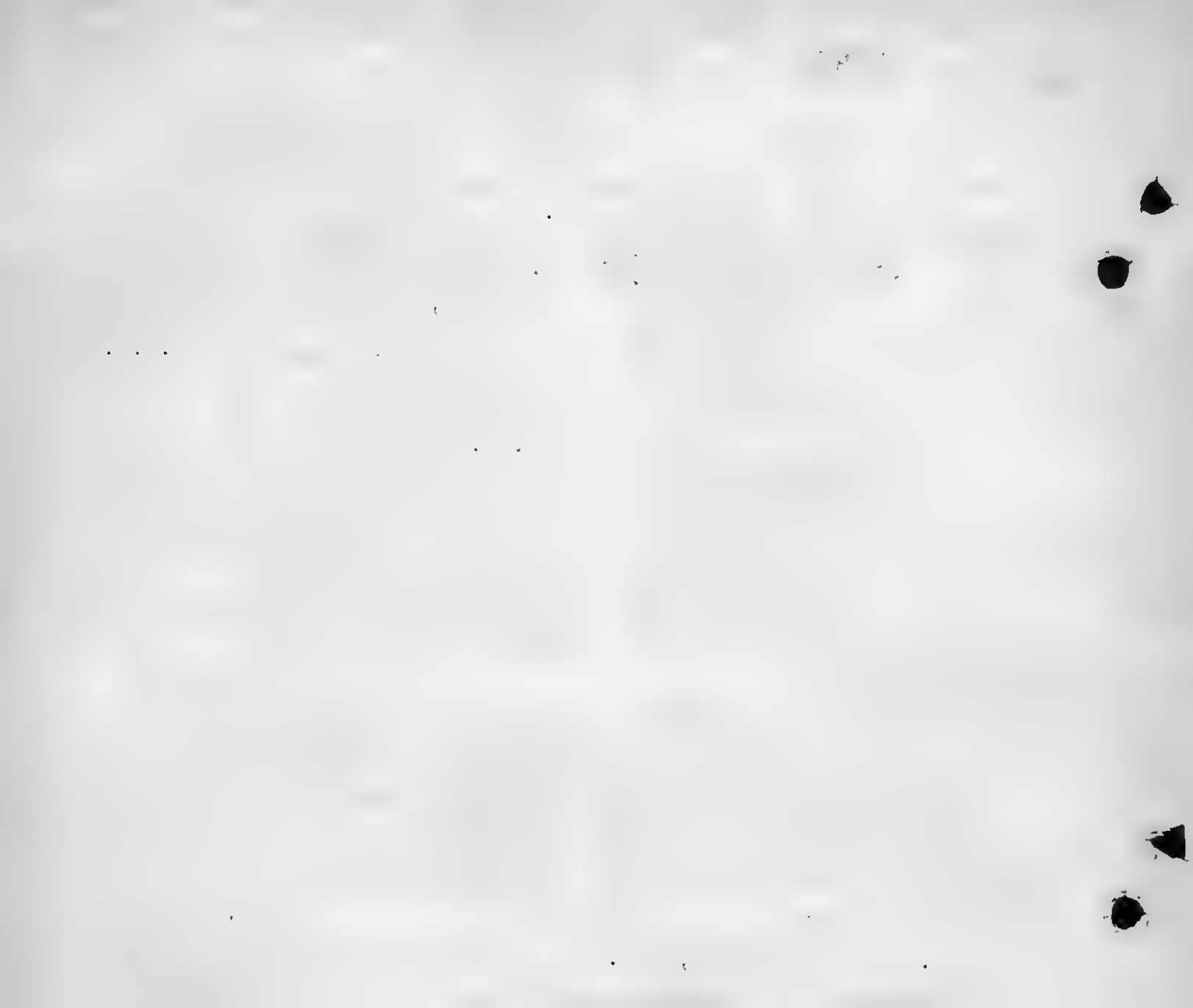
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03797

CERTIFICATE OF DEATH

03793

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN b. MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hosp.		e. STREET ADDRESS Ferry Farms		f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
3. NAME OF DECEASED (Type or print) Theodore Clifton BUCK		4. DATE OF DEATH 3 24 1962		5. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1869	
9. AGE (In years last birthday) 92 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hezekiah Best Buck		14. MOTHER'S MAIDEN NAME Emily Catherine Hoover	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. H. Marion Lazenby	
18. CAUSE OF DEATH (Enter only one cause per Part I, (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Lobular Pneumonia Conditions, if any, which gave rise to immediate cause (b) Chronic brain syndrome (e), stating the underlying cause last. (c) Cerebral arteriosclerosis		19. INTERVAL BETWEEN ONSET AND DEATH 6 days 4 years 4 years		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Generalized arteriosclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18		20c. TIME OF INJURY Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1961 to March 24, 1962 that (I) (no) last saw the deceased alive on March 24, 1962, and that death occurred at P.M. from the causes and on the date stated above.					
22a. SIGNATURE Young E. Chun		22b. DATE 12-40		22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN	
22d. ADDRESS 1500 Penna Ave Hagerstown, Md		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE Arthur S. Hanna	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-62		23c. NAME OF CEMETERY OR CREMATORY Loudon Park	
23d. LOCATION (City, town or county) Baltimore, Maryland		23e. NAME OF CEMETERY OR CREMATORY Loudon Park		23f. LOCATION (City, town or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		24b. ADDRESS 1900 Eutan Place		24c. DATE MAR 27 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03798											
03794											
Item 1 Film 0300 03794											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>MORGAN</u>							
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>BERKELEY SPRINGS</u> <u>85 X 12</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON Co. Hospital</u>				d. STREET ADDRESS <u>1221 NOKKIS ST</u>							
3. NAME OF DECEASED (Type or print) <u>RONALD NEVIN CAPPER JR.</u>				4. DATE OF DEATH <u>MARCH 2</u> <u>1962</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 3, 1962</u>		9. AGE (In years last birthday) <u>17</u>		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown-Wash. Co. 17</u>			
13. FATHER'S NAME <u>RONALD N. CAPPER</u>				14. MOTHER'S MAIDEN NAME <u>VERONICA LEE KONGEL</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>				17. INFORMANT <u>RONALD CAPPER - Berkeley Springs</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity & Sudden Death</u> <u>771</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Pituitary hormone of viscera</u>				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>62</u> , to <u>3/2</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>62</u> , and that death occurred at <u>7:22</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard A. Young</u>				22b. DATE SIGNED <u>3/2</u>				22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young M.D.</u>			
22d. ADDRESS <u>101 King St. Hagerstown, Md.</u>				22e. ADDRESS <u>101 King St. Hagerstown, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>3-4-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND</u>			
23d. LOCATION (City, town or county) <u>MORGAN Co. W. Va.</u>				23e. (State) <u>W. Va.</u>				23f. (Country) <u>USA</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Hunter</u>				24b. ADDRESS <u>BERKELEY SPRINGS</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 14 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles E. Hunter</u>				25c. ADDRESS <u>BERKELEY SPRINGS</u>							

CERTIFICATE OF DEATH

03796

03800

1. PLACE OF DEATH
e. COUNTY Washington MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE West Virginia b. COUNTY Martinsburg
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 215 W. Race St.
d. STREET ADDRESS 215 W. Race St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED
(Type or print) ANNA First Lyon Middle Chatkin Last
4. DATE OF DEATH March 23 1962
Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH Dec 25, 1888
9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Operator Store Store 10b. KIND OF BUSINESS OR INDUSTRY Europe 11. BIRTHPLACE (County & State, or foreign country) U.S.A
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Lyon 14. MOTHER'S MAIDEN NAME Minnie Sock's

15. WAS DECEASED EVER IN U.S. ARMED FORCES? no 16. SOCIAL SECURITY NO. Unable to Locate 17. INFORMANT Beulah Lyon (sister) Chambersburg Penna

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-vascular Collapse
DUE TO Acute gastroenteritis
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Severe DUE TO Arthur Lewis's
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 1-22 1961 to 3-23 1962
Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-22 1961 to 3-23 1962 that (II) (we) last saw the deceased alive on 2-23 1962 and that death occurred at 3:43 A.M. from the causes and on the date stated above.

22a. SIGNATURE ME BYRKIT 22b. DATE SIGNED 3-23-62
22c. PHYSICIAN'S NAME (Type) ME BYRKIT 22d. ADDRESS Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/25/62 23c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery 23d. LOCATION (City, town or county) Half way near Hagerstown (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md. 25a. REC'D BY REGISTRAR DATE MAR 27 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

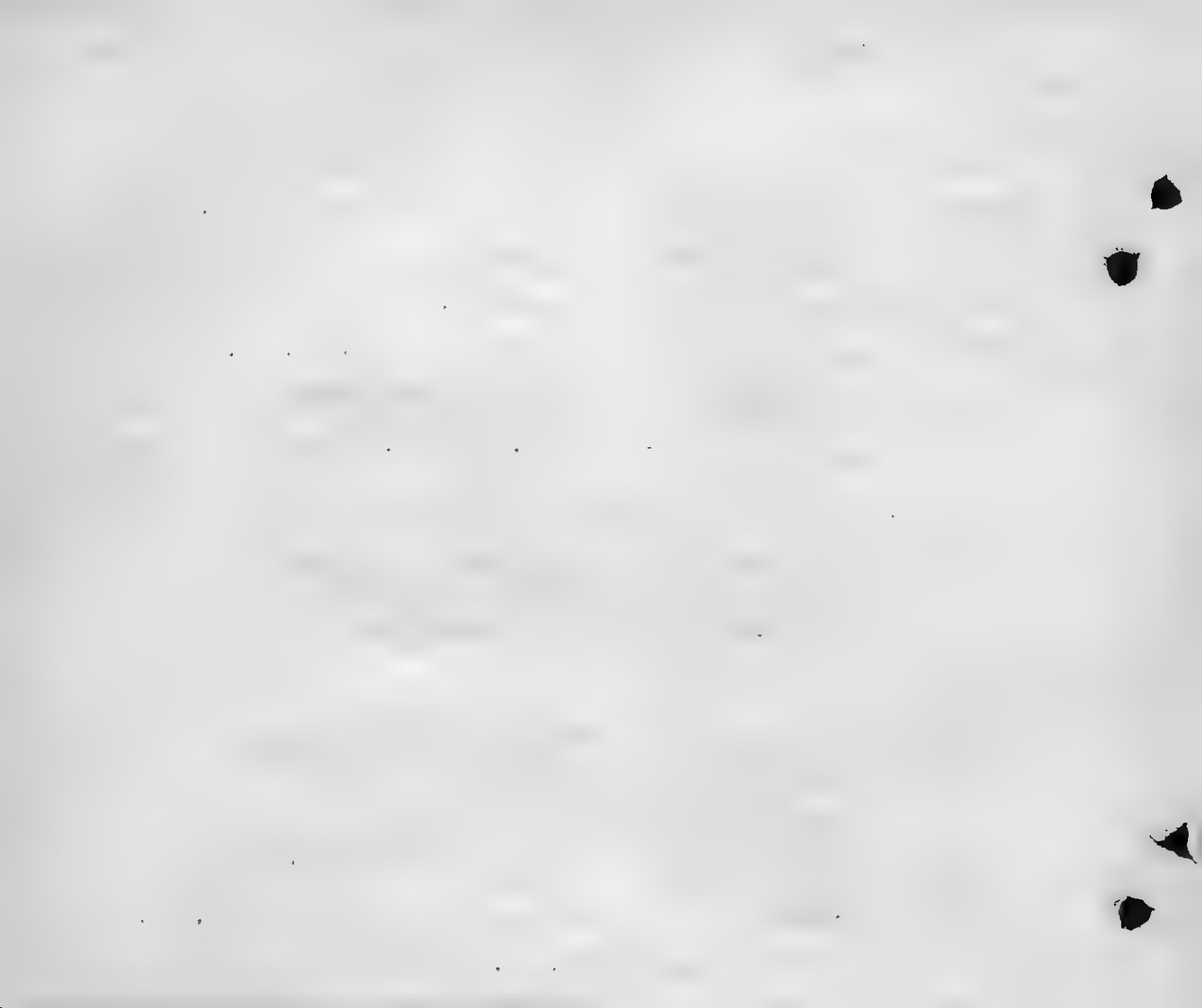
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03801 CERTIFICATE OF DEATH 03797

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 30 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 34 N. Locust St.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 34 N. Locust St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Reynolds Parker Divens		4. DATE OF DEATH Month Day Year March 30, 19 62		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1907 9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) finisher		10b. KIND OF BUSINESS OR INDUSTRY shoe mfg.		11. BIRTHPLACE (County & State, or foreign country) Knobsville, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lennuel Divens		14. MOTHER'S MAIDEN NAME Maude Myers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 214-09-5773 17. INFORMANT Address Melvin C. Rager, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Acute Alcoholism				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/27/62 to 3/30/62, that (I) (we) last saw the deceased alive on 3/30/62, and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE H. Beachley M.D.		22b. DATE SIGNED 3/31/62		22c. PHYSICIAN'S NAME (Type) H. Beachley		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-2-62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR APR 3 '62		25b. REGISTRAR'S SIGNATURE C. L. S. Thomas	



VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03803

03799

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 112 N. Mechanick Street		d. STREET ADDRESS 112 N. Mechanic Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence Daniel Easterday		4. DATE OF DEATH March 3 19 62		Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 26 1879		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 5 Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Near Sharpsburg Md.	
13. FATHER'S NAME Conrad Easterday		14. MOTHER'S MAIDEN NAME Abbie Johnson		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Clarence Easterday Sharpsburg Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung hemorrhage DUE TO (b) An infiltrating mass in the upper right lobe - probably malignant. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 50 days.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 22, 1962 to March 3 19 62 that (I) (we) last saw the deceased alive on March 3, 1962, and that death occurred at M, from the causes and on the date stated above		22a. SIGNATURE Walter H. Shealy M. D.		22b. DATE SIGNED 3/6/62	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22d. ADDRESS Sharpsburg, Md.		22e. REC'D BY REGISTRAR DATE 7 '62	
23a. BURIAL CREMAT. OR REMOVAL (Specify) Burial		23b. DATE THEREOF March 6-62		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	
23d. LOCATION (City, town or county) Sharpsburg Maryland		23e. REC'D BY REGISTRAR DATE 7 '62		23f. REGISTRAR'S SIGNATURE Clarence E. Johnson	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after the death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/60

1

(M)

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03804 CERTIFICATE OF DEATH 03800

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>12 Hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Rural Williamsport</u>	
3. NAME OF DECEASED (Type or print) <u>Evelyn Holmes Ebersole</u>		4. DATE OF DEATH <u>3-14-62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry Mat.</u>	
13. FATHER'S NAME <u>Warren M Seymore</u>		14. MOTHER'S MAIDEN NAME <u>Martha E Holmes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214.09.8388</u>	
17. INFORMANT <u>Richard M Ebersole</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive crisis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>12 hrs</u> (c) <u>14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>1962</u> Hour <u>3</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Williamsport Md.</u>		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>3-13-62</u> to <u>3-14-62</u> , that (1) (we) last saw the deceased alive on <u>3-14-62</u> , and that death occurred <u>11</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Byrkit</u>		22b. DATE SIGNED <u>3-16-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3.17.62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Washington Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Elmer</u>		24b. ADDRESS <u>Williamsport Md</u>	
25a. REC'D BY REGISTRAR <u>MAR 20 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

121
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03805 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03801

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN It 50 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAIRGROUND & POTOMAC AVENUES		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 842 HAMILTON BOULEVARD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT LESLIE EVANS SR.		4. DATE OF DEATH MARCH 1 1962	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 26, 1890	
9. AGE (In years, last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 1 1 1	
11. BIRTHPLACE (State or foreign country) ONVILLE VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWIN S. EVANS		14. MOTHER'S MAIDEN NAME MARY E. GARRISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-03-1111	
17. INFORMANT MRS. R.L. EVANS SR.		Address HAGERSTOWN MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20- coronary occlusion Conditions, if any, which gave rise to immediate cause (b) arterio sclerosis (c) sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT.ON GIVEN IN PART I(a) years		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.N. Weeks		M.D. 3-5-62 DATE SIGNED 3-5-62	
EXAMINER'S NAME (Type) HOWARD N WEEKS M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 136 N POTOMAC ST.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-5-62	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		22d. LOCATION (City, town, or country) (State) HAGERSTOWN MARYLAND	
23. FUNERAL DIRECTOR Charles M. Rouzer		24a. REC'D BY REGISTRAR HAGERSTOWN MARYLAND	
24b. REGISTRAR'S SIGNATURE Charles M. Rouzer		DATE MAR 9 '62	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03806

03802

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN It <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>52 1/2 East Antietam St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> <u>ARTHUR</u> <u>FAHRNEY</u>		4. DATE OF DEATH <u>March 29 1962</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13 1881</u>
9. AGE (In years last birthday) <u>80 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign birth) <u>Mad Beaver Creek Wash Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William O. Fahrney</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Hartle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>172-03-3700 A.</u>	
17. INFORMANT <u>Paul Fahrney</u>		Address <u>108 Fairground Ave Hagerstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vas. Accident</u> DUE TO <u>Gen. arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town, (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> , 19 <u>62</u> , to <u>3/29</u> , 19 <u>62</u> , that (I) (two) last saw the deceased alive on <u>3/29</u> , 19 <u>62</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence E. Coffman</u>		22b. DATE SIGNED <u>APR 3 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence E. Coffman</u>		22d. ADDRESS <u>119 E. Antietam</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/31/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Smithsburg Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kline</u>	
ADDRESS <u>Hagerstown Md.</u>		DATE <u>APR 3 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. Page 6 may be retained by the attending physician and completely filled in by the funeral director. Page 7 may be retained by the attending physician and completely filled in by the funeral director. Page 8 may be retained by the attending physician and completely filled in by the funeral director. Page 9 may be retained by the attending physician and completely filled in by the funeral director. Page 10 may be retained by the attending physician and completely filled in by the funeral director. Page 11 may be retained by the attending physician and completely filled in by the funeral director. Page 12 may be retained by the attending physician and completely filled in by the funeral director. Page 13 may be retained by the attending physician and completely filled in by the funeral director. Page 14 may be retained by the attending physician and completely filled in by the funeral director. Page 15 may be retained by the attending physician and completely filled in by the funeral director. Page 16 may be retained by the attending physician and completely filled in by the funeral director. Page 17 may be retained by the attending physician and completely filled in by the funeral director. Page 18 may be retained by the attending physician and completely filled in by the funeral director. Page 19 may be retained by the attending physician and completely filled in by the funeral director. Page 20 may be retained by the attending physician and completely filled in by the funeral director. Page 21 may be retained by the attending physician and completely filled in by the funeral director. Page 22 may be retained by the attending physician and completely filled in by the funeral director. Page 23 may be retained by the attending physician and completely filled in by the funeral director. Page 24 may be retained by the attending physician and completely filled in by the funeral director. Page 25 may be retained by the attending physician and completely filled in by the funeral director. Page 26 may be retained by the attending physician and completely filled in by the funeral director. Page 27 may be retained by the attending physician and completely filled in by the funeral director. Page 28 may be retained by the attending physician and completely filled in by the funeral director. Page 29 may be retained by the attending physician and completely filled in by the funeral director. Page 30 may be retained by the attending physician and completely filled in by the funeral director. Page 31 may be retained by the attending physician and completely filled in by the funeral director. Page 32 may be retained by the attending physician and completely filled in by the funeral director. Page 33 may be retained by the attending physician and completely filled in by the funeral director. Page 34 may be retained by the attending physician and completely filled in by the funeral director. Page 35 may be retained by the attending physician and completely filled in by the funeral director. Page 36 may be retained by the attending physician and completely filled in by the funeral director. Page 37 may be retained by the attending physician and completely filled in by the funeral director. Page 38 may be retained by the attending physician and completely filled in by the funeral director. Page 39 may be retained by the attending physician and completely filled in by the funeral director. Page 40 may be retained by the attending physician and completely filled in by the funeral director. Page 41 may be retained by the attending physician and completely filled in by the funeral director. Page 42 may be retained by the attending physician and completely filled in by the funeral director. Page 43 may be retained by the attending physician and completely filled in by the funeral director. Page 44 may be retained by the attending physician and completely filled in by the funeral director. Page 45 may be retained by the attending physician and completely filled in by the funeral director. Page 46 may be retained by the attending physician and completely filled in by the funeral director. Page 47 may be retained by the attending physician and completely filled in by the funeral director. Page 48 may be retained by the attending physician and completely filled in by the funeral director. Page 49 may be retained by the attending physician and completely filled in by the funeral director. Page 50 may be retained by the attending physician and completely filled in by the funeral director. Page 51 may be retained by the attending physician and completely filled in by the funeral director. Page 52 may be retained by the attending physician and completely filled in by the funeral director. Page 53 may be retained by the attending physician and completely filled in by the funeral director. Page 54 may be retained by the attending physician and completely filled in by the funeral director. Page 55 may be retained by the attending physician and completely filled in by the funeral director. Page 56 may be retained by the attending physician and completely filled in by the funeral director. Page 57 may be retained by the attending physician and completely filled in by the funeral director. Page 58 may be retained by the attending physician and completely filled in by the funeral director. Page 59 may be retained by the attending physician and completely filled in by the funeral director. Page 60 may be retained by the attending physician and completely filled in by the funeral director. Page 61 may be retained by the attending physician and completely filled in by the funeral director. Page 62 may be retained by the attending physician and completely filled in by the funeral director. Page 63 may be retained by the attending physician and completely filled in by the funeral director. Page 64 may be retained by the attending physician and completely filled in by the funeral director. Page 65 may be retained by the attending physician and completely filled in by the funeral director. Page 66 may be retained by the attending physician and completely filled in by the funeral director. Page 67 may be retained by the attending physician and completely filled in by the funeral director. Page 68 may be retained by the attending physician and completely filled in by the funeral director. Page 69 may be retained by the attending physician and completely filled in by the funeral director. Page 70 may be retained by the attending physician and completely filled in by the funeral director. Page 71 may be retained by the attending physician and completely filled in by the funeral director. Page 72 may be retained by the attending physician and completely filled in by the funeral director. Page 73 may be retained by the attending physician and completely filled in by the funeral director. Page 74 may be retained by the attending physician and completely filled in by the funeral director. Page 75 may be retained by the attending physician and completely filled in by the funeral director. Page 76 may be retained by the attending physician and completely filled in by the funeral director. Page 77 may be retained by the attending physician and completely filled in by the funeral director. Page 78 may be retained by the attending physician and completely filled in by the funeral director. Page 79 may be retained by the attending physician and completely filled in by the funeral director. Page 80 may be retained by the attending physician and completely filled in by the funeral director. Page 81 may be retained by the attending physician and completely filled in by the funeral director. Page 82 may be retained by the attending physician and completely filled in by the funeral director. Page 83 may be retained by the attending physician and completely filled in by the funeral director. Page 84 may be retained by the attending physician and completely filled in by the funeral director. Page 85 may be retained by the attending physician and completely filled in by the funeral director. Page 86 may be retained by the attending physician and completely filled in by the funeral director. Page 87 may be retained by the attending physician and completely filled in by the funeral director. Page 88 may be retained by the attending physician and completely filled in by the funeral director. Page 89 may be retained by the attending physician and completely filled in by the funeral director. Page 90 may be retained by the attending physician and completely filled in by the funeral director. Page 91 may be retained by the attending physician and completely filled in by the funeral director. Page 92 may be retained by the attending physician and completely filled in by the funeral director. Page 93 may be retained by the attending physician and completely filled in by the funeral director. Page 94 may be retained by the attending physician and completely filled in by the funeral director. Page 95 may be retained by the attending physician and completely filled in by the funeral director. Page 96 may be retained by the attending physician and completely filled in by the funeral director. Page 97 may be retained by the attending physician and completely filled in by the funeral director. Page 98 may be retained by the attending physician and completely filled in by the funeral director. Page 99 may be retained by the attending physician and completely filled in by the funeral director. Page 100 may be retained by the attending physician and completely filled in by the funeral director.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03807 CERTIFICATE OF DEATH 03803

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>23 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>519 Brown Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Charles Farrow</u> First Middle Last 4. DATE OF DEATH <u>March 16, 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 9, 1876</u> 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Clearspring, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Nathan Farrow</u> 14. MOTHER'S MAIDEN NAME <u>Lucetta Silvers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Arthur Burgan</u> Address <u>519 Brown Ave. Hagerstown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ischemic myocardial fibrosis</u> DUE TO (c) <u>or severe atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ischemic myocardial fibrosis</u> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I. or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>Feb. 23, 1962</u> Hour a.m. <u>19</u> p.m. <u>4:35</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 23, 1962</u> to <u>March 16, 1962</u> that (I) (we) last saw the deceased alive on <u>March 16, 1962</u> and that death occurred at <u>4:35 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Victor L. Ramos, M.D.</u> 22b. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u> 22c. ADDRESS <u>Western Maryland State Hospital Hagerstown, Maryland</u> 22d. DATE SIGNED <u>March 16, 1962</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/19/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Reformed Church</u> 23d. LOCATION (City, town or county) (State) <u>St. Pauls Wash. Co. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> 25a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> DATE <u>MAR 20 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03808

03804

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Hagerstown</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>(D.C.)</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5015 27th Ave. Hillcrest Hgts</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hagerstown Hospital</u>		f. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1962</u>	
3. NAME OF DECEASED (Type or print) <u>Rowena Mable FEERRAR</u>		g. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Mins. <u>0</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24 1899</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>IRA Stepp</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Bender</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ralph E. Ferrar R.O.#1 Jersey Shore Pa.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lobular Pneumonia</u> (c) <u>Gastric Ulcer, Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One week</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>Hypertensive Cardiovascular disease Cholecystopathia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 22, 1961</u> to <u>March 25, 1962</u> that (I) (we) last saw the deceased alive on <u>March 25, 1962</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun M.D.</u>		22b. DATE SIGNED <u>March 25, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna. Ave Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/28/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Jersey Shore</u>		23d. LOCATION (City, town or county) (State) <u>Jersey Shore Lycoming PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Owen Kelchner</u>		24a. ADDRESS <u>Jersey Shore Pa.</u>	
25a. REC'D BY REGISTRAR <u>MAR 28 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03809

CERTIFICATE OF DEATH

03805

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md		c. LENGTH OF STAY IN 1b 75 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 W. Bethel Street		d. STREET ADDRESS 31 W. Bethel Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amos Middle (no) Last Felmon		4. DATE OF DEATH Month Mar Day 4 Year 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 90 yrs.
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Private family	
11. BIRTHPLACE (State or foreign country) Mercersburg Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 219-20-0461	
17. INFORMANT Mrs. Nathan William		Address 30 W Bethel St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with congestive failure DUE TO (c) Not known			INTERVAL BETWEEN ONSET AND DEATH 12 hr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 3, 1962 to March 4, 1962 that (I) (we) last saw the deceased alive on March 3, 1962 , and that death occurred on March 4, 1962 at 2:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE B. B. Knolesley		22b. DATE SIGNED March 6, 1962	
22c. PHYSICIAN'S NAME (Type) B. B. Knolesley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 10 1962	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson		25. REC'D BY REGISTRAR Mar 12 '62	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE J. R. Kram	

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ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death of the deceased. If the deceased is retained by the hospital or attending physician, the certificate shall be filled in by the attending physician and the physician's signature shall be retained by the hospital or attending physician. If the deceased is not retained by the hospital or attending physician, the certificate shall be filled in by the attending physician and the physician's signature shall be retained by the attending physician. The law requires that the death certificate be executed within 24 hours after the death of the deceased.

RECTOR: After this certificate has been signed by the attending physician and the physician's signature shall be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death of the deceased. If the deceased is retained by the hospital or attending physician, the certificate shall be filled in by the attending physician and the physician's signature shall be retained by the hospital or attending physician. If the deceased is not retained by the hospital or attending physician, the certificate shall be filled in by the attending physician and the physician's signature shall be retained by the attending physician. The law requires that the death certificate be executed within 24 hours after the death of the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03810 CERTIFICATE OF DEATH 03806

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>434 S. Potomac Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Noah Garfield Ford</u>		4. DATE OF DEATH <u>March 15 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 27 1881</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		9b. AGE (In years last birthday) <u>81</u> yrs. <u>0</u> months <u>15</u> days	
10a. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		10b. BIRTHPLACE (County & State, or foreign country) <u>Boonesboro Md.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Emma Frances Horine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Beulah G Kauffman</u>	
17. INFORMANT <u>Hagerstown Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Indefinite</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Adenocarcinoma of the gall bladder was the immediate cause of this illness</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Non functioning gall bladder; emphysema; arthritis, lumbodorsal</u>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>min.</u> <u>pm.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from <u>5-3-55</u> , 19....., to <u>death</u> , 19....., that (I) (we) last saw the deceased alive on <u>March 14, 191962</u> and that death occurred <u>at 3:30 AM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Robert F. Keadle</u> M.D.	
22b. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>		22c. ADDRESS <u>Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 18-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Boonesboro Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Boonesboro Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williamsport, Md.</u>		25. REC'D BY REGISTRAR <u>March 19 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03811

03807

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 347 N. Cleveland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth First Blanche Middle Gardner Last 4. DATE OF DEATH March 4 1962 Month March Day 4 Year 1962		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 1, 1898 9. AGE (In years last birthday) 64 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward Mongan 14. MOTHER'S MAIDEN NAME Daisy Strock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 216014-6354 17. INFORMANT James H. Gardner Address Hagerstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis Of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent INTERVAL BETWEEN ONSET AND DEATH Recent	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 2-27- 1962 , to 3-4- 1962 that (I) (we) last saw the deceased alive on 3-4- 1962 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. E. W. Ditto, Jr. 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED 3-5-62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 215 W. Washington St., Hagerstown, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3-7-62 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown, Md. 25a. REC'D BY REGISTRAR MAR 7 '62 25b. REGISTRAR'S SIGNATURE Charles A. Minnich			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

03812

03808

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN b. <u>6 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>125 E. ANTIETAM ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>VIRGINIA</u> Last <u>GARLING</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30 1898</u>
9. AGE (In years last birthday) <u>63 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALEXANDER H KNIGHT</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>MR. HARRY M GARLING HAGERSTOWN MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic coronary vascular disease</u> DUE TO (b) <u>Acute myocardial infarct</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes M</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 2 '62</u> , 19 <u>62</u> , to <u>Mar 7 '62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>March 7 & 19 62</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold R. Titch Jr</u>		22b. DATE SIGNED <u>3/6/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Physician acting while family</u> <u>H R TRITCH JR. M. D. Dr out of town</u>		22d. ADDRESS <u>102 N POTOMAC ST. HAGERSTOWN MARYLAND</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-10-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Fowler</u> SUPERVISOR FEDERAL HOME <u>HAGERSTOWN MARYLAND</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 13 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles M. Fowler</u>			

MEDICAL CERTIFICATION

IN HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03813

CERTIFICATE OF DEATH

03809

1. PLACE OF DEATH
a. COUNTY *Washington* MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Hagerstown*
c. LENGTH OF STAY IN b. *4 Day*
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) *Western Md. State Hosp*

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE *Maryland* b. COUNTY *Montgomery*
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Gaithersburg Md*
d. STREET ADDRESS *Rural*
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last *PAUL EDWARD GAYLOR*
4. DATE OF DEATH Month Day Year *MARCH 12 1962*

5. SEX *Male* **6. COLOR OR RACE** *White* **7. MARRIED** ☐ NEVER MARRIED ☒ **8. DATE OF BIRTH** *Set 21/1917*
9. AGE (In years last birthday) *44* yrs. **IF UNDER 1 YEAR** Months Days *4 29* **IF UNDER 24 HRS.** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Laborer* **10b. KIND OF BUSINESS OR INDUSTRY** *Van* **11. BIRTHPLACE** (County & State, or foreign country) *Va* **12. CITIZEN OF WHAT COUNTRY? *USA***

13. FATHER'S NAME *Walter Gaylor* **14. MOTHER'S MAIDEN NAME** *Ella Haysett*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *No* **16. SOCIAL SECURITY NO.** *230-20-0497* **17. INFORMANT** *Hospital Records* Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *CARDIAC HYPERTROPHY*
527.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) *PULMONARY EMPHYSEMA*
(c) *UNKNOWN*
(e), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) *INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS*

20a. ACCIDENT WAS UNDERLYING ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. *19* **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

21. I certify that (I) (~~him~~) attended the deceased from *3-8-1962* to *3-12-1962* that (I) (~~was~~) last saw the deceased alive on *3-12-1962* and that death occurred at *12:15* from the causes and on the date stated above.

22a. SIGNATURE *Antonio U. Pallagris* **22b. DATE SIGNED** *3-12-1962*
22c. PHYSICIAN'S NAME (Type) *ANTONIO U. PALLAGRISI* **22d. ADDRESS** *1500 PA AVE HAGERSTOWN MD*

23a. BURIAL, CREMATION, REMOVAL, DISSECTION *Buried* **23b. DATE THEREOF** *3/16/62* **23c. NAME OF CEMETERY OR CREMATORY** *Greenwood* **23d. LOCATION** (City, town or county) (State) *Rockville Va Md*

24. FUNERAL DIRECTOR'S SIGNATURE *Ernest E. Gantner* **25a. REC'D BY REGISTRAR** *William L. Finner* **25b. REGISTRAR'S SIGNATURE** *William L. Finner*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health, Baltimore 1, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03814

03810

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY NIB <u>68 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> d. STREET ADDRESS <u>3605 Taylor St</u>	
3. NAME OF DECEASED (Type or print) <u>Douglas Blaine GRAY</u> First Middle Last 4. DATE OF DEATH <u>3 14 1962</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-15-23</u> Last 9. AGE (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Syracuse, N.Y.</u>	
11. FATHER'S NAME <u>John Campbell Gray</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. MOTHER'S M maiden name <u>Goodheart</u>		14. MOTHER'S M maiden name <u>Goodheart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>Unable to locate</u>	
17. INFORMANT <u>deceased</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per organ (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> <u>Carcinoma of floor of mouth</u> Conditions, if any, which gave rise to immediate cause (b) <u>14</u> (c) <u>15 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>one week</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 5</u> , 19 <u>62</u> to <u>March 14</u> , 19 <u>62</u> that (I) <u>(me)</u> last saw the deceased alive on <u>March 14</u> , 19 <u>62</u> and that death occurred at <u>10:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u> M.D.		22b. DATE SIGNED <u>March 15 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reburial</u>		23b. DATE THEREOF <u>3-15-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Medical School</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. L. Hoffman</u>		24. ADDRESS <u>Hagerstown Md</u>	
25a. REC'D BY REGISTRAR <u>MAR 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>C. S. S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03815

CERTIFICATE OF DEATH

03811

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>22 yrs.</u>		d. STREET ADDRESS <u>10 Marbern Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Lynn Gregg</u>		4. DATE OF DEATH <u>March 18 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1920</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flight Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Garfield Gregg</u>		14. MOTHER'S M.A.DEN NAME <u>Jessie Carroll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>216-14-6810</u>	
17. INFORMANT <u>Mrs. Chas. L. Gregg</u>		Address <u>10 Marbern Rd. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>720.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1962</u> to <u>March 18, 1962</u> that (I) (two) last saw the deceased alive on <u>March 15, 1962</u> and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffner</u> M.D.		22b. DATE SIGNED <u>3/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffner</u>		22d. ADDRESS <u>214 N. Potomac St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/21/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25. REC'D BY REGISTRAR <u>Arthur S. Finner</u>	
25a. DATE <u>MAR 21 '62</u>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03816
03812

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN, MD. c. LENGTH OF STAY IN b. FEW MIN. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL 1 CLEAR SPRING, MD. d. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) JOHN IRA GROVE		4. DATE OF DEATH Month Day Year MARCH 6, 1962	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH JAN. 10, 1882 9. AGE (In years last birthday) Months Days 80 yrs 1 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country) WASH. CO. MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL GROVE		14. MOTHER'S MAIDEN NAME CHRISTINA STECK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS ANNA GROVE		Address ROUTE 1, CLEAR SPRING MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4 IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Chronic Hypertensive DUE TO (c) Cardiac Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1962 to Mar. 6, 1962 that (I) (we) last saw the deceased alive on Mar. 5, 1962 and that death occurred at 12 P. from the causes and on the date stated above.			
22a. SIGNATURE David R. Brewer 22c. PHYSICIAN'S NAME (Type) David R. Brewer		22b. DATE SIGNED 3/7/62 22d. ADDRESS Clear Spring Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/9/1962	
23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town or county) (State) WESTERN PIKE, CLSPG. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret Rowland		25a. REC'D BY REGISTRAR MAR 12 '62 25b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove early papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY
Washington
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Hagerstown
c. LENGTH OF STAY IN 1b
2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Washington County Hospital

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

2 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF DECEASED
(Type or print)

Harry

Oscar

Harbaugh

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

W DOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Sept. 12, 1900

9. AGE (In years last birthday)

61 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farm-Owner

10b. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (County & State, or foreign country)

Lantz, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Oscar Harbaugh

14. MOTHER'S MAIDEN NAME

Rebecca Holtzman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

215-36-6952

17. INFORMANT

Mrs. Lydia M. Harbaugh Hag. Rt. 4

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4-20.0

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c)

Coronary occlusion
arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

2 days
2 yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not White at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 16 DEC. 1960 to 27 MAR. 1962 that (I) (we) last saw the deceased alive on 27 MARCH 1962, and that death occurred at 10:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

RICHARD T. BINFORD, M. D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

28 MARCH, 62

22d. ADDRESS

1135 POTOMAC AVENUE HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-29-62

23c. NAME OF CEMETERY OR CREMATORY

Green Hill Cemetery

23d. LOCATION (City, town or county)

Waynesboro, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 29 '62

Arthur S. Hines

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03818

03814

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>1/2</u> Hour	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clear Spring Rt. #2</u>	
3. NAME OF DECEASED (Type or print) <u>ROY POWERS HARP</u>		d. STREET ADDRESS <u>Spicklers</u>	
5. SEX <u>Male</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1962</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>October 15, 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Chewsville, Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>David Harp</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Beard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wilbur U. Harp, Boonesboro, Md. Rt. #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <u>arterio-sclerosis</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LT. LENA</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hagerstown Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Andrew K. Coffman, Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 23 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>3/20/62</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03819

03815

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <u>LIFE</u> c. LENGTH OF STAY IN <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1213 SHERMAN AVENUE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>1213 SHERMAN AVENUE</u>			
3. NAME OF DECEASED (Type or print) <u>ARTHUR DAVID HASENBUHLER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>19 62</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 4 1922</u>			
9. AGE (In years last birthday) <u>39 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) <u>DETECTIVE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LOUIS HASENBUHLER</u>		14. MOTHER'S MAIDEN NAME <u>MABEL V. BUTTS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW 2</u>		16. SOCIAL SECURITY NO. <u>215-26-1230</u>		17. INFORMANT <u>MRS. A D HASENBUHLER HAGERSTOWN MARYLAND</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> (b) <u>Coronary atherosclerosis</u> (c) <u>see yes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>see yes</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.							
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> <u>1962</u> to <u>3/24</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> <u>1962</u> and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard N. Weeks M.D.</u> 22b. DATE SIGNED <u>MARCH 24 1962</u>							
22c. PHYSICIAN'S NAME (Type) <u>HOWARD N WEEKS M. D.</u> 22d. ADDRESS <u>136 N POTOMAC ST. HAGERSTOWN MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3-24-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u> 23d. LOCATION (City, town or county) <u>HAGERSTOWN MARYLAND</u> (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. House</u> 25a. REC'D BY REGISTRAR <u>MAR 30 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>							
26. SUTHER-CROZIER FUNERAL HOME HAGERSTOWN MARYLAND							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03820

03817

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b. 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 22 BROADWAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE VIRGINIA HOCKMAN		4. DATE OF DEATH Month Day Year MARCH 10 19 62	
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 13 1876 9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY CULPEPPER VIRGINIA 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN W JENKINS		14. MOTHER'S MAIDEN NAME FRANCES V JENKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS HELEN NEWCOMER HAGERSTOWN MARYLAND Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1450.0 DUE TO congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO arteriosclerosis genl. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Yeast Intoxication		INTERVAL BETWEEN ONSET AND DEATH 1 day 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/15/59 19 to 3/11/62 19 , that (I) (we) last saw the deceased alive on 3/7/62 19 , and that death occurred at 2 PM , from the causes and on the date stated above.			
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) HOWARD N WEEKS M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 136 N POTOMAC ST. HAGERSTOWN MARYLAND 22b. DATE SIGNED 3-12-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 3-13-62		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY 23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE SUPER ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR MAR 15 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03821

03816

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> STREET ADDRESS <u>RD 6 - Hagerstown, Md.</u> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma</u> First Middle Last <u>Emma</u> <u>Clara</u> <u>Hollenshead</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>1</u> <u>1962</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 13, 1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Welsh Run, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Angle</u>		14. MOTHER'S MAIDEN NAME <u>Moriah Hawbaker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>RD 6</u> <u>Frank E. Hollenshead - Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED PERITONITIS</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PERFORATED Sigmoid Diverticulitis</u> (c) <u>" "</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOGENIC CA OF RT. LUNG & Mediastinal METASTASES</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/62</u> to <u>3/1/62</u> , 19 <u>62</u> , that (I) was last saw the deceased alive on <u>3/1/62</u> 19 <u>62</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John A. Moran M.D.</u>		22b. DATE SIGNED <u>3/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN M.D.</u>		22d. ADDRESS <u>215 W. WASHINGTON ST.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>3/4/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shanks Cem.</u>		23d. LOCATION (City, town or county) (State) <u>near Greencastle, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich. Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>6 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the funeral director. Page 6 should be filled in by the attending physician and completely filled in by the funeral director. Pages 7 and 8 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03822

CERTIFICATE OF DEATH

03818

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>2 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>1929 YORK ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES TYLER HOUCK</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 26 1909</u>	
9. AGE (in years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR ESTIMATOR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN LUTHER HOUCK</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE MOFFETT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-8532</u>	
17. INFORMANT <u>MRS. CHARLES T HOUCK HAGERSTOWN MARYLAND</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio Vascular Disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year: <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>HAGERSTOWN</u>		20g. (County) <u>MARYLAND</u>	
20h. (State) <u>MARYLAND</u>		21. I certify that (I) (this hospital) attended the deceased from <u>3-19-62</u> 19 <u>to</u> <u>3-20</u> 1962 that (I) (we) last saw the deceased alive on <u>3-20-62</u> and that death occurred at <u>6 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>A. E. W. Ditto Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E.W. DITTO JR. M.D.</u>		22d. ADDRESS <u>215 W WASHINGTON ST. HAGERSTOWN MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-23-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		23d. LOCATION (City, town or county) <u>HAGERSTOWN MARYLAND</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SUTER-HOUZER FUNERAL HOME HAGERSTOWN MARYLAND</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2, and return them to be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, 72 hours after death.

VR A15 (4)
ISM 7-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03823
CERTIFICATE OF DEATH
03819

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN IT <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital (DOA)</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>25 Glenside Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Margaret</u> First Middle Last 4. DATE OF DEATH <u>March 30 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 30, 1904</u> 9. AGE (in years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>David E. Kershner</u> 14. MOTHER'S MAIDEN NAME <u>Laura Emma Tronte</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. Roy M. Houser</u> Address <u>25 Glenside Ave. Hagerstown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Arterio sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>minutes</u> (c) <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from <u>Jan. 2, 1958</u> to <u>3/30</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> , 19 <u>62</u> and that death occurred at <u>7:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Elden D. Woodlander</u> 22c. PHYSICIAN'S NAME (Type) <u>Elden D. Woodlander</u>		22b. DATE SIGNED <u>3/31/62</u> 22d. ADDRESS <u>Hagerstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>April 2, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>	
24. FURNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 3 '62</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Walter S. Thomas</u>	

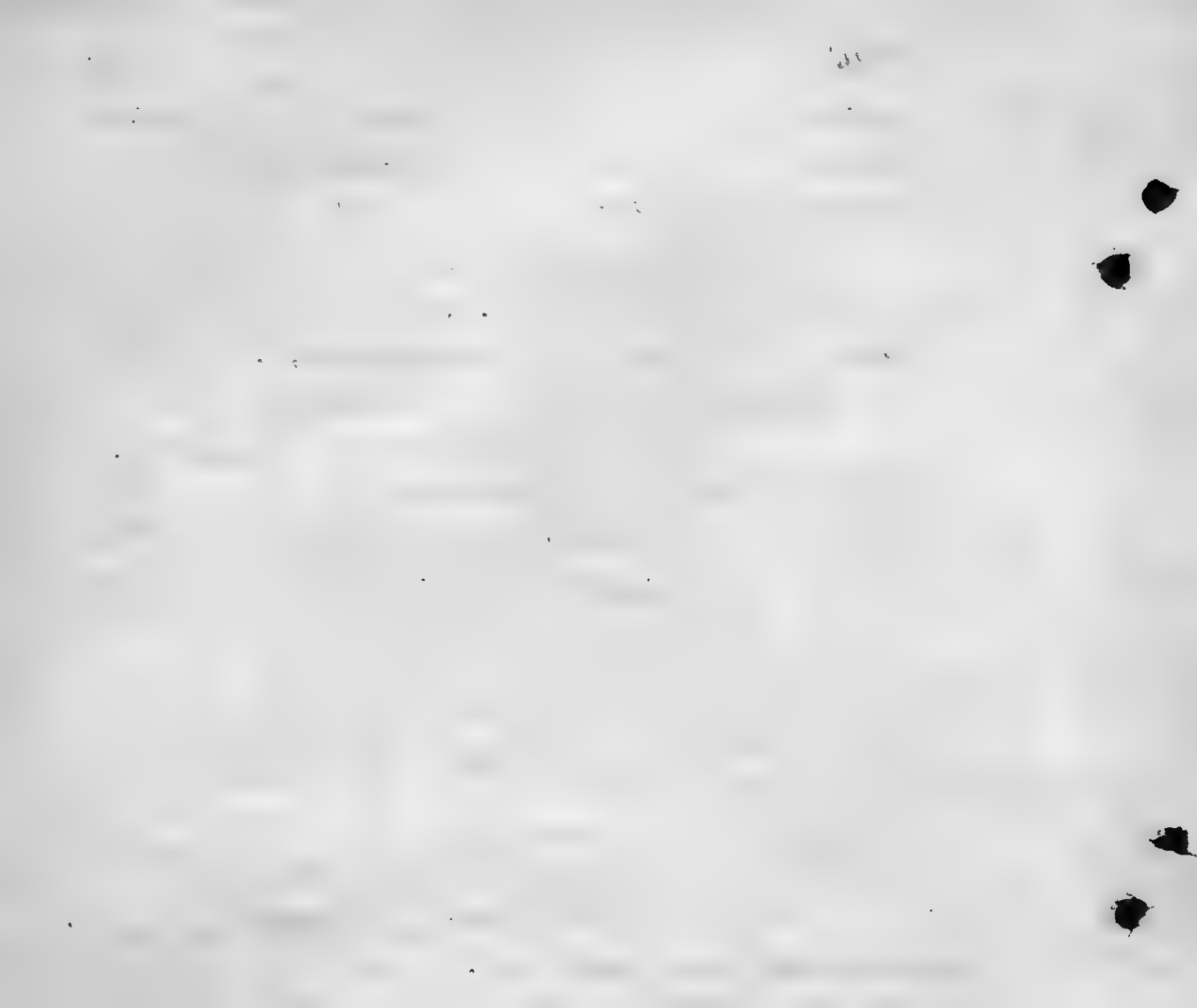
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03824 CERTIFICATE OF DEATH 03820

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 4</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>R # 4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Lee HULL</u>		4. DATE OF DEATH <u>3 4 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 27, 1882</u>	
9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>79</u> yrs. Months Days Hours M'n.		10. BIRTHPLACE (County & State or foreign country) <u>Washington County, Md.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Malinda Hull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Mary Hull R # 4 Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Generalized Arteriosclerosis</u> DUE TO <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 Weeks</u> <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 16, 1962</u> to <u>March 4, 1962</u> that (I) (we) last saw the deceased alive on <u>March 4, 1962</u> and that death occurred at <u>4:30</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u>		22b. DATE SIGNED <u>March 4, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>W. G. Stork</u>	
25b. REGISTRAR'S SIGNATURE <u>W. G. Stork</u>		25c. DATE <u>Mar 6 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03825

03821

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Hagerstown</u> c. LENGTH OF STAY IN b <u>49 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Wash. Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1019 Rose Hill Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth Irene Hungate</u> f. SEX <u>Female</u> g. COLOR OR RACE <u>White</u> h. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> i. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> j. DATE OF DEATH <u>March 4 1962</u> k. AGE (In years last birthday) <u>50</u> yrs l. IF UNDER 1 YEAR Months Days m. IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>March 4 1962</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Martinsburg, W. Va.</u> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Abram French</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>William H. Hungate</u> 17. INFORMANT <u>William H. Hungate</u> Address <u>Hagerstown, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Maude Mongan</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>Cerebral arteriosclerosis</u> <u>Malignant Hypertension</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>5 yrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from... <u>7/7</u> to... <u>3/12</u> , 1962, that (I) (we) last saw the deceased alive on... <u>3/12</u> , 1962, and that death occurred at... <u>1:30</u> P.M., from the causes and on the date stated above.		22b. DATE SIGNED <u>3-5-62</u>	
22a. SIGNATURE <u>Paul Harrison</u> 22c. PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u>		22d. ADDRESS <u>318 N. Potomac St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-6-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>W.P.</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u> ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>W.P.</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons of pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03826

Items 00, 9 & 14 Film 3508 3/8/62 iwk

03822

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>465 Mitchell Ave.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Roy</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown 1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	
11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fertilizer-Chemical</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Taylor Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>421-03-1038</u>	
17. INFORMANT <u>Mrs. John H. Smith</u>		Address <u>465 Mitchell Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } DUE TO (b) _____ DUE TO (c) _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____		INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/2/62</u> , 19 <u>62</u> , to <u>3/2/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/2/62</u> , 19 <u>62</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ralph F. Young</u>		22b. DATE SIGNED <u>3/3/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young M.D.</u>		22d. ADDRESS <u>Williamsport, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/4/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>6 '62</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03827
03823

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY IN 1b 60yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 650 Penna. Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. d. STREET ADDRESS 650 Penna Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William T Johnson		4. DATE OF DEATH Month Mar Day 5 Year 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 17 1879
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	11. BIRTHPLACE (County & State, or foreign country) Frederick Md.
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	
16. SOCIAL SECURITY NO. 220-09-7428		17. INFORMANT Walter E Campher Address 650 Penna Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive failure DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO malnutrition PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition			
INTERVAL BETWEEN ONSET AND DEATH 3 days years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/3 1962 to 3/5 1962 that (I) (we) last saw the deceased alive on 3/5 1962 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks, M.D.			
22b. DATE SIGNED 3/7/62			
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.			
22d. ADDRESS 136 N. Potomac Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Mar 9 1962			
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
23d. LOCATION (City, town or county) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown Md.			
25a. REC'D BY REGISTRAR MAR 12 '62			
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03828

03824

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Rural Hol-</u>	
c. LENGTH OF STAY IN TB <u>1 yr 2 mo 18 da</u>		d. STREET ADDRESS <u>Mid-State Hosp-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mid-State Hosp-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCES LAVINIA JONES</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11th 1905</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>56 yrs.</u>	9d. IF UNDER 1 YEAR Months <u>2</u> Days <u>26</u>
10a. FATHER'S NAME <u>Reginald Cross</u>	10b. MOTHER'S MAIDEN NAME <u>Emma J. Whaling</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Seneca, Md.</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	13. SOCIAL SECURITY NO.	14. INFORMANT <u>Address</u>	

15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO (b) _____ DUE TO (c) _____		16. INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis & cervical spondylitis and quadriplegia</u>		
17a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19a. TIME OF INJURY Hour <u>19</u> e.m. p.m.	19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20a. (City or town)	20b. (County)	20c. (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19</u> 19 <u>60</u> to <u>March 7</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>March 7</u> 19 <u>62</u> , and that death occurred at <u>4:55 PM</u> from the causes and on the date stated above.		
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>	22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>	22e. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 10, '62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>
23d. LOCATION (City, town or county)	23e. (State) <u>Beallsville, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Fisher Gaithersburg Md</u>	25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>	25b. REGISTRAR'S SIGNATURE <u>C. L. & H. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be relayed by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 03825

03829

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. NONE b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. COUNTY HOSPITAL		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN RUSSELL JUDD, JR.		4. DATE OF DEATH Month Day Year MARCH 19 1962	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19 1962
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN RUSSELL JUDD SR.		14. MOTHER'S MAIDEN NAME VIOLET VIRGINIA FLOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MOTHER		Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atrial ectasis, bilateral (c) Immediate INTERVAL BETWEEN ONSET AND DEATH 15-min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Harold H. Gist M.D. PHYSICIAN'S NAME (Type) DR. H. H. GIST, HAGERSTOWN, MD.			
22a. BURIAL (CREMATION, REMOVAL) (Specify) 21 Mar 62		22b. DATE THEREOF 21 Mar 62	
22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hosp.		22d. LOCATION (City, town, or county) (State) Hagerstown	
23. FUNERAL DIRECTOR'S SIGNATURE John Schaffer, adms. Wash. Co. Hosp.		24a. REC'D BY REGISTRAR DATE MAR 22 '62	
24b. REGISTRAR'S SIGNATURE Arthur E. Kneass			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03830 CERTIFICATE OF DEATH 03826

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHANKTOWN, MD.</u> c. LENGTH OF STAY IN 1b <u>56 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RESIDENCE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHANKTOWN</u> d. STREET ADDRESS <u>NONE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES D. KAYLOR</u>		4. DATE OF DEATH <u>MAR. 4, 1962</u>		5. SEX <u>MALE</u>	
6. CO. OR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 10, 1874</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		9. AGE (In years last birthday) <u>88 yrs.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HAMPSHIRE CO. W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ANDREW KAYLOR</u>	
14. MOTHER'S MAIDEN NAME <u>CATHERINE MILES</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS ZETA MURRAY KAYLOR, SHANKTOWN, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Dis</u> DUE TO (b) <u>5 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Fractured Hip (Nonunion) 1960</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1960</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15, 1960 to Mar 4, 1962</u> that (I) (we) last saw the deceased alive on <u>Mar 4, 1962</u> and that death occurred at <u>3:00 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>David R. Brewer</u>		22b. DATE SIGNED <u>3/5/62</u>		22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>	
22d. ADDRESS <u>Clear Spring Md.</u>		22e. REC'D BY REGISTRAR <u>MAR 8 '62</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 7, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SHANKTOWN CEMETERY</u>	
23d. LOCATION (City, town or county) <u>SHANKTOWN, MD.</u>		23e. NAME OF CEMETERY OR CREMATORY <u>SHANKTOWN, MD.</u>		23f. LOCATION (City, town or county) <u>SHANKTOWN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Margaret Rowland</u>		24b. ADDRESS <u>CLEAR SPRING, MD.</u>		24c. REC'D BY REGISTRAR <u>MAR 8 '62</u>	
24d. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		24e. REC'D BY REGISTRAR <u>MAR 8 '62</u>		24f. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 must be completely filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03831 CERTIFICATE OF DEATH 03827

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY IN b <u>3-Months.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>York</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accokeek, Md.</u> d. STREET ADDRESS <u>P.O. Box 487.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edgar James Kearney</u> First Middle Last 5. SEX <u>M.</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-6-1894</u> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paving Contractor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>HARRISBURG-PA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lawrence Kearney</u> 14. MOTHER'S MAIDEN NAME <u>Katherine Palmer</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>116-12-7612</u> 17. INFORMANT <u>J. Henry Smyser</u> Address <u>1640 Clifton Lane York Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive heart failure.</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ulcerative colitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>6 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2-14</u> , 19 <u>62</u> to <u>3-23</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3-23</u> , 19 <u>62</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u> M.D. 22b. DATE SIGNED <u>3-23-1962</u> 22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u> 22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3-27-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u> 23d. LOCATION (City, town or county) (State) <u>York - PENNA.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u> ADDRESS <u>Hagerstown, Md.</u> 25a. REC'D BY REGISTRAR <u>MAR 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03832

CERTIFICATE OF DEATH

03828

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) INDIAN SPRINGS c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RESIDENCE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) INDIAN SPRINGS d. STREET ADDRESS RURAL e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL TANNER KEEFER		4. DATE OF DEATH Month MARCH Day 17 Year 19 62	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/15/1871	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 8 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (County & State, or foreign country) COVE GAP, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER KEEFER		14. MOTHER'S MAIDEN NAME HENRIETTA EICHELBERGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT S.A. KEEFER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 15, 19 59 to March 17, 19 62 , that (I) (we) last saw the deceased alive on March 16, 19 62 , and that death occurred at 12:30 AM from the causes and on the date stated above.		22a. SIGNATURE Archie Robert Cohen, M.D.	
22b. DATE SIGNED 3/17/62		22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.	
22d. ADDRESS Clear Spring, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/19/1962	
23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town or county) (State) WESTERN PIKE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret Rauland		25a. REC'D BY REGISTRAR DATE MAR 20 '62	
25b. REGISTRAR'S SIGNATURE Arthur E. Hume		25c. ADDRESS CLEAR SPRING, MD.	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03833

CERTIFICATE OF DEATH

03829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN b. <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>120 N. MAIN ST.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>120 NORTH MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) <u>MARGARET ELIZABETH KERNS</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 22, 1894</u>				9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>25</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u> DATE OF DEATH <u>MARCH 17, 1962</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u> 11. BIRTHPLACE (County & State, or foreign country) <u>BOONSBORO WASH. CO. MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>DAVID O. LAKIN</u> 14. MOTHER'S MAIDEN NAME <u>DELLA HOFFMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>214-09-9628</u>				17. INFORMANT <u>KENNETH KERNS BOONSBORO</u> Address <u>IXID</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>196.2</u> DUE TO <u>Coronary Thrombosis -</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, <u>Cancer of spine</u> (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September 2, 1961</u> to <u>March 17, 1962</u> that (I) (we) last saw the deceased alive on <u>March 16, 1962</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Hedden</u> 22c. PHYSICIAN'S NAME (Type) <u>G. W. Hedden</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Boonsboro, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 20, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Post</u> ADDRESS <u>BOONSBORO MD.</u>				25a. REC'D BY REGISTRAR <u>MAR 22 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kins</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03834

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03830

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 should be executed and the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>205 E. Lincoln Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u> d. STREET ADDRESS <u>15 S. 15 Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Jane King</u>		4. DATE OF DEATH <u>March 4 19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1887</u> 9. AGE (In years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Carlisle, Penn.</u>
13. FATHER'S NAME <u>John Fyler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Beecher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>George L. King</u>		Address <u>Harrisburg, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20</u> } DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <u>General Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>recent</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. W. Ditto Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>215 W. Washington St. Hag. Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-6-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Harrisburg, Pa.</u>	
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>		24a. REC'D BY REG STRAR <u>7 '62</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03835 CERTIFICATE OF DEATH 03831

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN It <u>6 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gateway Conv Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>Y.M.C.A.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> <u>KELLER</u> <u>LANTZ</u>		4. DATE OF DEATH <u>March 12 1962</u> 19 <u>19</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 3 1878</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M.N.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md. news Leitersburg Wash Co</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles L. Lantz</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Katherine Zentmyer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>219-20-3836</u> 17. INFORMANT <u>Webster W. Lantz 115 West Magnolia Ave Hagerstown Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 260X DUE TO (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Diabetic Gangrene Both legs amputated</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>9 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>53</u> to <u>Mar 12, 1962</u> that (I) (we) last saw the deceased alive on <u>Mar 12, 1962</u> and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David R. Brewer M.D.</u> 22b. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u> 22c. ADDRESS <u>Clear Spring Md.</u>		22d. DATE SIGNED <u>3/14/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/15/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hall Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md</u> 25a. REC'D BY REGISTRAR <u>DATE MAR 19 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Quinn S. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03836

03832

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN b. <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>321 LINGANORE AVENUE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>321 LINGANORE AVENUE</u>			
3. NAME OF DECEASED (Type or print) <u>CARTIE</u> <u>VIOLA</u> <u>LAWRENCE</u>		4. DATE OF DEATH <u>MARCH</u> <u>19</u> <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 4, 1892</u>			
9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN HER OWN HOME</u>			
11. BIRTHPLACE (County & State or foreign country) <u>WASHINGTON CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE FRANKLIN MILLS</u>			
14. MOTHER'S MAIDEN NAME <u>MARGARET E. SHRADER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-28-9101</u>			
17. INFORMANT <u>GEORGE H. LAWRENCE</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhages; 1st June 1, 1961</u> Conditions, if any, which gave rise to immediate cause (b) <u>" 2nd Mar 19, 1962</u> (c) <u>arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)		21. I certify that (I) (this hospital) attended the deceased from <u>1 June 1961</u> to <u>19 Mar 1962</u> that (I) (we) last saw the deceased alive on <u>19 Mar 1962</u> and that death occurred at <u>6:05 P</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Dr. Frank F. Lusby</u>			
22c. PHYSICIAN'S NAME (Type, <u>DR. FRANK F. LUSBY</u>)		22d. ADDRESS <u>220 N. POTOMAC ST. HAGERSTOWN, MD.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>21 Mar 62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/22/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL CEMETERY</u>			
23d. LOCATION (City, town or county, (State) <u>WASHINGTON, MARYLAND</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>SUTHER-ROUZER FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>MAR 27 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. REGISTRAR'S NAME <u>Arthur S. Thomas</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03837

03833

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>2112 VIRGINIA AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>GUY</u> Middle <u>MOHLER</u> Last <u>LONG</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>DEC</u> Day <u>18</u> Year <u>1882</u>	
9. AGE (in years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL STORE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DOWNSVILLE WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSHUA LONG</u>		14. MOTHER'S MAIDEN NAME <u>IDA C. WELTY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-14-9381</u>	
17. INFORMANT <u>MISS THELMA BAKER WILLIAMS</u>		18. ADDRESS <u>PORTMD. R.I.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>11-1-1-1</u> (b) <u>Congestive Heart failure?</u> DUE TO (c) <u>fx of 3 Ribs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>2 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> <u>1962</u> to <u>3-8</u> <u>1962</u> that (II) (we) last saw the deceased alive on <u>3-7</u> <u>1962</u> , and that death occurred at <u>3:45</u> <u>PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>3-9-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 10. 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>NEAR TILGH MANTON MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Bass</u>		24b. REC'D BY REGISTRAR <u>MAR 13 '62</u>	
ADDRESS <u>BOONSBORO MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Francis</u>	

DR BYRKIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN b. <u>30 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>428 WEST WASH. ST.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>428 W. WASH. ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LULA LONG</u>		4. DATE OF DEATH <u>MARCH 5 1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 16 1876</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		12. IF UNDER 24 HRS. Hours <u>5</u> Min. <u>19</u>	
13. FATHER'S NAME <u>DANIEL SMITH</u>		14. MOTHER'S MAIDEN NAME <u>MATILDE GELTNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-6999</u>	
17. INFORMANT <u>MISS ALBERTA LONG</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis and</u> Conditions, if any, which gave rise to immediate cause (b) <u>Paternal heart disease</u> (c) <u>5-10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1 1958</u> to <u>Mar 5 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 1 1962</u> and that death occurred at <u>PM</u> from the causes and on the date stated above.		22. SIGNATURE <u>Edward W. Ditto III, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 8 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROCKERSVILLE CEMETERY</u>		23d. LOCATION (City, town or county) <u>ROCKERSVILLE WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Datto - BOONSBORO MD</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 13 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. DATE <u>MAR 13 '62</u>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

M

X

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03835									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN TB 6 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1015 Hamilton Blvd.					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) e. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1015 Hamilton Blvd. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Mary A. Martin 4. DATE OF DEATH Month Day Year March 23 1962					5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH May 9, 1897 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Martin 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 218-38-1613 17. INFORMANT Joseph P. Martin, Maugansville, Md.					14. MOTHER'S MAIDEN NAME Anna Gearhart Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) arteriosclerosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/23/62									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Howard N. Weeks, M. D. Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/25/62 22c. NAME OF CEMETERY OR CREMATORY Cedar Grove, ADDRESS Greencastle, Pa. 22d. LOCATION (City, town, or country) (State) Near Greencastle, Pa.									
23. FUNERAL DIRECTOR A. E. Minnich 24a. REC'D BY REGISTRAR DATE MAR 27 '62 24b. REGISTRAR'S SIGNATURE Charles S. Hanna									

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03836

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural) Williamsport		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Williamsport	
c. LENGTH OF STAY IN 1b 3 mo 21 days		d. STREET ADDRESS Williamsport RFD #1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport RFD #1			
3. NAME OF DECEASED (Type or print) Carolyne Annette Mauck	First Carolyne	Middle Annette	Last Mauck
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28 1961
9. AGE (In years last birthday) 3 yrs. 3 months 21 days		10. IF UNDER 1 YEAR 3 months 21 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Ralph Mauck		14. MOTHER'S MAIDEN NAME Shirley Holland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Ralph Mauck RFD #1		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) viral pneumonia	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. 32X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1. 32X		DUE TO (b) 1. 32X DUE TO (c) 1. 32X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 1. 32X			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. H. Weaks		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24-62	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or country) (State) Williamsport Md.	
23. FUNERAL DIRECTOR Arthur S. Hines		24a. REC'D BY REGISTRAR DATE MAR 27 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03841
CERTIFICATE OF DEATH
03837

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN Is <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>936 CHESTNUT STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TRA CLIFFORD MCCLELLAND</u> First Middle Last 4. DATE OF DEATH <u>MARCH 5 1962</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>OCTOBER 6, 1880</u> 9. AGE (In years last birthday) <u>81 yrs.</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONARY ENGINEER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u> 11. BIRTHPLACE (County & State, or foreign country) <u>LINGANORE MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN W MCCLELLAND</u> 14. MOTHER'S MAIDEN NAME <u>AGNES V BARNES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>197-10-8458A</u> 17. INFORMANT <u>MRS. HAROLD L SMITH HAGERSTOWN MARYLAND</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>8/5/60</u> , 19 <u>60</u> , to <u>3/5</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>62</u> , and that death occurred at <u>AP</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Howard N Weeks</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3/7/62</u> 22c. PHYSICIAN'S NAME (Type) <u>HOWARD N WEEKS M. D.</u> 22d. ADDRESS <u>136 N POTOMAC ST. HAGERSTOWN MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3-8-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u> ADDRESS <u>SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</u> 23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MARYLAND</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 13 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. S. Hines</u>	

MEDICAL CERTIFICATION

SPINAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03842

CERTIFICATE OF DEATH

03838

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN b <u>2 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>W. Va</u> b. COUNTY <u>MORGAN</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERKELEY SPRINGS</u> d. STREET ADDRESS <u>RFD # 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TINA CATHERINE MICHAEL</u> First Middle Last 4. DATE OF DEATH <u>MARCH 19, 1962</u> Month Day Year		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 26, 1895</u> 9. AGE (In years last birthday) <u>66</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HODGESVILLE, W. Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> 13. FATHER'S NAME <u>WILLIAM TEDRICK</u> 14. MOTHER'S MAIDEN NAME <u>ELIZA LINTON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>Mrs. S. Myers - PITTSBURGH, Pa.</u> 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 4 25 25 } DUE TO (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> indeterminate 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Pneumonitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) <u>W. T. Layman</u> attended the deceased from <u>March 6, 1962</u> to <u>March 19, 1962</u> , that (I) <u>W. T. Layman</u> saw the deceased alive on <u>March 19, 1962</u> , and that death occurred at <u>9:10 pm</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. T. Layman</u> 22b. DATE SIGNED <u>3-21-62</u> 22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> 22d. ADDRESS <u>5 Public Square Hagerstown, Maryland</u>		22e. REC'D BY REGISTRAR <u>3-21-62</u> 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3-22-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u> 23d. LOCATION (City, town or county) (State) <u>MORGAN Co. W. Va.</u>		23e. REC'D BY REGISTRAR <u>3-22-62</u> 23f. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03843 CERTIFICATE OF DEATH 03839

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waynesboro	
c. LENGTH OF STAY in lb 1 wk.		d. STREET ADDRESS 87 W. Main St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LLOYD CALVIN MILLER		4. DATE OF DEATH March 7 1962	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1909
9. AGE (in years last birthday) 52 yrs.		10. IF UNDER 1 YEAR: Months 52 Days 7 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pattern Maker		10b. KIND OF BUSINESS OR INDUSTRY Washington Co., Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chauncey C. Miller		14. MOTHER'S MAIDEN NAME Edith Weddle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 173 03 3836	
17. INFORMANT Mrs. Lloyd C. Miller		Address Waynesboro, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER DUE TO GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (b) 18/0 (c), stating the underlying cause last. 18/0		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (i) (this hospital) attended the deceased from 1-28-56 , 19... to 3-7- 19... that (i) (we) last saw the deceased alive on 3-7-62 , 19... and that death occurred at 5 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. G. Warden		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. G. WARDEN, M. D.		22d. ADDRESS 832 Potomac Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/10/62	23c. NAME OF CEMETERY OR CREMATORY Green Hill	23d. LOCATION (City, town or county) (State) Waynesboro, Penna.
24. FUNERAL DIRECTOR'S SIGNATURE Walter J. Stone		25a. REC'D BY REGISTRAR March 12 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

Page 5 may be retained by the funeral director.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03844
03840

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE RURAL</u> d. STREET ADDRESS <u>KEEDYSVILLE MD. R. 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>URILLA B. MILLER</u> 4. SEX <u>FEMALE</u> 5. COLOR OR RACE <u>WHITE</u> 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. DATE OF BIRTH <u>DECEMBER 2, 1885</u> 8. AGE (In years last birthday) <u>76</u> yrs. <u>3</u> months <u>20</u> days <u>0</u> hours <u>0</u> min.		9. DATE OF DEATH <u>MARCH 22, 1962</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASH. CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STAN MILTON BEELER</u> 14. MOTHER'S MAIDEN NAME <u>SALLIE BENNETT</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>E. CARLTON MILLER, KEEDYSVILLE MD. R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of face</u> 175, 1 DUE TO <u>diffuse metastasis to ribs & pelvis</u> Conditions, if any, which gave rise to immediate cause (b) <u>5 years</u> (a), stating the underlying cause last. DUE TO (c) <u>3 months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Compst. v. Heart failure</u>		20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1951</u> to <u>March 21, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 21, 1962</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Joseph Secondary</u> 22b. DATE SIGNED <u>March 21, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARY</u>		22d. ADDRESS <u>BOONSBORO MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MARCH 24, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Card</u> 25a. REC'D BY REGISTRAR <u>DATE MAR 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Kline</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03845

03841

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 103 East Washington St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William McPherson MILLER First Middle Last 4. DATE OF DEATH 3 23 1962 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov 23 1885 Month Day Year 9. AGE (In years last birthday) 76 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Dealer Self Employed 10b. KIND OF BUSINESS OR INDUSTRY Hagerstown Wash Co Md 11. BIRTHPLACE (Country & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Miller		14. MOTHER'S MAIDEN NAME Mary Butts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 165-10-8555 17. INFORMANT Mrs Minnie B. Miller Address 103 E. Washington, Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) lobular pneumonia DUE TO (b) Neurotizing renal papillitis DUE TO (c) Carcinoma of bladder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) one week INTERVAL BETWEEN ONSET AND DEATH unknown 2 years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-27-1962 to 3-23-1962 that (I) last saw the deceased alive on 3-23-1962, and that death occurred at 9:55 from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun 22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22b. DATE SIGNED 3-23-1962 22d. ADDRESS 1500 Penna. Ave Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/25/62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE Mar 27 '62	

VA 15 (4)

15M 7-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

STATE OF MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03846

CERTIFICATE OF DEATH

03842

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 52 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Lester Mongan Sr.		4. DATE OF DEATH Month March Day 18 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH May 12, 1894	19. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (County & State or foreign country) Brunswick, Md.	
13. FATHER'S NAME Christopher Mongan		14. MOTHER'S MAIDEN NAME Annie Dunn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) no		16. SOCIAL SECURITY NO. 214-09-8663	
17. INFORMANT Mrs. Frances B. Mongan		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Hypertensive cardiovascular disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 5 yr.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 8, 1957 to March 18, 1962 , that (I) (we) last saw the deceased alive on March 18, 1962 , and that death occurred at 8:55a from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED March 19, 1962	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Gardens		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.		25a. REC'D BY REGISTRAR March 22 '62	
25b. REGISTRAR'S SIGNATURE Clara S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VK A15 (4)
15M 7-61

DR. SECONDARY

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03847
CERTIFICATE OF DEATH
03843

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MAPLEVILLE ROAD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm'ss on) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>MAPLEVILLE ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERTUS D. MULLENDORF</u> First Middle Last 4. DATE OF DEATH <u>MARCH 8, 1962</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEBRUARY 15, 1900</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>23</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL INSURANCE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>ROCKERSVILLE WASH. CO. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NOAH O. MULLENDORF</u> 14. MOTHER'S MAIDEN NAME <u>CLEMMIE EASTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>213-10-7033</u> 17. INFORMANT <u>MRS. FRANCES MULLENDORF</u> Address <u>BOONSBORO MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>March 3-5, 1962</u> to <u>March 8, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1962</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Joseph K. SECONDARY</u> 22c. PHYSICIAN'S NAME (Type) <u>Joseph K. SECONDARY</u> 22b. ADDRESS <u>BOONSBORO MD</u> 22d. DATE <u>3. 10. 62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MARCH 11, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u> 23d. LOCATION (City, town or county) <u>BOONSBORO WASH. CO. MD.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> 25b. REGISTRAR'S SIGNATURE DATE <u>MAR 13 '62</u>	

1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>2204 Rowland Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Erny</u> Middle <u>May</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>19 62</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1888</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u>	IF UNDER 24 HRS. Hours <u>73</u> Min. <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Tilghmanton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Moats</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Rohrer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. A. C. Palmer 1216 Glenwood Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>903.0</u> IMMEDIATE CAUSE (a) <u>fractured skull</u> DUE TO (b) <u>accidental fall</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>1 day</u> DUE TO (c) <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depression</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stool slipped from person climbing onto it in an attempt at hanging herself. She then fell striking her head on basement floor.</u>					
20c. TIME OF INJURY Hour <u>6:30 a.m.</u> Month, Day, Year <u>Mar 1, 19 62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. N. WEEKS</u>		EXAMINER'S NAME (Type) <u>H. N. WEEKS</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/5/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>		ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Mar 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 18 Film 309

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03850

03846

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN TB MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9718 Wichita Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TERESA BLAKE QUINN Middle Last Female White f. SEX g. COLOR OR RACE h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> i. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife j. KIND OF BUSINESS OR INDUSTRY Own Home k. BIRTH-PLACE (County & State or foreign country) Washington D. C. l. CITIZEN OF WHAT COUNTRY? U. S. A.		4. DATE OF DEATH Month MARCH Day 10 Year 1962 m. DATE OF BIRTH Aug. 13, 1883 n. AGE (In years last birthday) 78 o. IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Mins. 00 p. IF UNDER 24 HRS. Hours 3 Mins. 00 Seconds 00	
13. FATHER'S NAME Francis Blake 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no 16. SOCIAL SECURITY NO. 579-09-1345 17. INFORMANT Ruth Anderson Same as #2 (Daughter) Address		14. MOTHER'S MAIDEN NAME Barbara Kelley 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 10 HOURS RECENT DUE TO ACUTE (b) CORONARY OCCLUSION 4 HOURS RECENT DUE TO (c) CORONARY ATHEROSCLEROSIS UNKNOWN CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (e), stating the underlying cause last. Old myocardial infarction 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) CARDIAC HYPERTROPHY WITH HYPERTENSION 20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-22-1962 to 2-10-1962 that (I) last saw the deceased alive on 3-10-1962, and that death occurred at 5:20 P.M. from the causes and on the date stated above. 22a. SIGNATURE Antonio U. Pallagrosi M.D. 22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI 22b. DATE SIGNED 22d. ADDRESS 1500 Pa Ave. Hagerstown Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/13/62 23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Church 23d. LOCATION (City, town or county) (State) Collington, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons ADDRESS Hyattsville, Md. 25a. REC'D BY REGISTRAR DATE MAR 13 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03851

03847

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Rural - Hagerstown</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hagerstown RDC</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> d. STREET ADDRESS <u>Hagerstown RDC</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susanna E. Reiff</u> 4. DATE OF DEATH <u>March 12, 1962</u> 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/31/1871</u> 9. AGE (In years if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) <u>90</u> yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. PLACE OF BIRTH <u>Reid, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Eschleman</u> 14. MOTHER'S M maiden name <u>Susanna Horst</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u> 16. SOCIAL SECURITY NO. <u>NO</u> 17. INFORMANT <u>Mrs. Martin Showalter</u> Address <u>RDC Hwy., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> + 4 1 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease.</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 3, 1962</u> to <u>Mar. 12, 1962</u> that (I) (we) last saw the deceased alive on <u>Mar. 11, 1962</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R.A. Bell</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Mar. 13, 1962.</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u> 22d. ADDRESS <u>119 N. Potomac St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> 23b. DATE THEREOF <u>3/15/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Paradise Cem.</u> 23d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Pa.</u> ADDRESS <u></u> 25a. REC'D BY REGISTRAR <u>DATE MAR 15 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03852

Item 1 Form 3309 1/17/62 iwk

Reg. Dist. No. 03848

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b FEW MINUTES X CLEAR SPRING, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) in yard of his home		d. STREET ADDRESS NONE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BOYD MARTIN ROBINSON		4. DATE OF DEATH MARCH 10 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 28, 1916
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 0 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXPIDITOR		10b. KIND OF BUSINESS OR INDUSTRY FAIRCHILD STRATOS	
11. BIRTHPLACE (State or foreign country) CLEAR SPRING, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. ROBINSON		14. MOTHER'S MAIDEN NAME MARY ESTHER RUEBECK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 216-14-5956	
17. INFORMANT MRS MARIE ROBINSON		Address CLSPG. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, Severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH Instant Recent	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		DATE SIGNED 3-12-62	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/13/1962	
22c. NAME OF CEMETERY OR CREMATORY BROADFORDING CEMETERY		22d. LOCATION (City, town, or county) (State) BROADFORDING MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Margaret Rowland		24a. REC'D BY REGISTRAR DATE MAR 14 '62	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03853

CERTIFICATE OF DEATH

03849

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>847 West Washington St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRENE CHARLOTTE RUTH</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> 8. DATE OF BIRTH <u>July 18 1883</u> 9. AGE (In years last birthday) <u>78 yrs.</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		4. DATE OF DEATH <u>March 24 1962</u> 13. FATHER'S NAME <u>Lewis Lohman</u> 14. MOTHER'S MAIDEN NAME <u>Annie Miller</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Miss Helen M.L. Ruth 847 W. Washington St Hagerstown Md.</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis and B.B. Block.</u> DUE TO <u>Arteriosclerotic Heart Disease.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>July 1959</u> to <u>Mar. 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar. 24, 1962</u> , and that death occurred at <u>8AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>R.A. Bell</u> 22b. DATE SIGNED <u>Mar. 26, 1962</u> 22c. PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u> 22d. ADDRESS <u>119 N. Potomac St. Hagerstown, Md.</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/26/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> 23d. LOCATION (City, town or county) <u>Hagerstown Wash Co Md</u> 23e. (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u> 25a. REC'D BY REGISTRAR <u>MAR 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

020854

03850

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 30 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital		d. STREET ADDRESS 141 West Franklin St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM HENRY SELBY		4. DATE OF DEATH March 2 1962		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH June 14 1885		9. AGE (In years: last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Union Bridge Carroll Co	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Noah P. Selby		14. MOTHER'S MAIDEN NAME Ella M. Slonaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Miss Ruth V. Selby	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) 2 years		19. INTERVAL BETWEEN ONSET AND DEATH 10 days		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent CVA - (2-3-62) with residual hemiparesis, left.		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. DATE SIGNED 3-3-	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this person) attended the deceased from Feb. 3 1962 to March 2 1962 , that (I) (we) last saw the deceased alive on March 2 1962 , and that death occurred at 7:55 pm from the causes and on the date stated above.		22a. SIGNATURE W. J. Layman		22b. DATE SIGNED 3-3-	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland		22e. DATE SIGNED 3-3-	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/5/62		23c. NAME OF CEMETERY OR CREMATORY Mt View Cemetery	
23d. LOCATION (City, town or county) Union Bridge Carroll Co Md		23e. DATE OF DEATH March 2 1962		23f. REGISTRAR'S SIGNATURE Andrew K. Coffman	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Andrew K. Coffman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and fill them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 days after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03855 CERTIFICATE OF DEATH 03851

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 14 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 765 S. Potomac St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 765 S. Potomac St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) QUINCY 4. DATE OF DEATH March 28, 1962		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 10, 1881 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home Building 11. BIRTHPLACE (County & State, or foreign country) Bedford Co. Penna. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Shaffer		14. MOTHER'S MAIDEN NAME Charlotte Robb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 175-16-8991		17. INFORMANT W. Shaffer Address Bedford, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arteriosclerotic Cardiovascular disease DUE TO (b) DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 1/2 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 Mar 1962 to 28 Mar 1962 , that (I) (we) last saw the deceased alive 28 Mar 1962 , and that death occurred at 5 P.M. from the causes and on the date stated above.			
22a. SIGNATURE F.F. Lusby M.D.		22b. DATE SIGNED 28 Mar 62	
22c. PHYSICIAN'S NAME (Type) F.F. Lusby		22d. ADDRESS 2304 Potomac St Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3-31-62		23c. NAME OF CEMETERY OR CREMATORY Schellsburg Cemetery 23d. LOCATION (City, town or county) (State) Schellsburg-Bedford Co. Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Ralph Mickle ADDRESS Schellsburg Pa.		25a. REC'D BY REGISTRAR DATE APR 2 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

03856

CERTIFICATE OF DEATH

03852

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY (in hospital, give street address) 3 Month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Charles g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural La Plata h. STREET ADDRESS Welcome i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD Charles 4. DATE OF DEATH MARCH 28 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 12 1898 9. AGE (in years, last birthday) 63 yrs. 7 months 15 days 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman 10b. KIND OF BUSINESS OR INDUSTRY For Estate 11. BIRTHPLACE (County & State, or foreign country) Williamsport Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William H. Sharer 14. MOTHER'S MAIDEN NAME Sarah Grosh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 220-10-3963 17. INFORMANT Mrs. C. G. Payne Address 29 S. Conococheague St. Williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 45 years (b) CORONARY ATHEROSCLEROSIS (c) GENERALIZED ATHEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter: nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from 12-18 1961 , to 3-28 1962 that (I) (we) last saw the deceased alive on 3-28 1962 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosti 22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSTI		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 1506 Pa Ave Hagerstown Md.	
23a. BURIAL, CREMATION, DATE THEREOF (Specify) Burial March 31-62		23b. NAME OF CEMETERY OR CREMATORY Riverview Cemetery 23c. LOCATION (City, town or county) (State) Williamsport Maryland	
24. REGISTRAR'S SIGNATURE Albert L. Reed ADDRESS Williamsport, Md.		25a. REC'D BY REGISTRAR MAR 30 '62 25b. REGISTRAR'S SIGNATURE Albert L. Reed	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copy, page 3 should be detached for use as the burial-transit permit. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03857

CERTIFICATE OF DEATH

Reg. Dist. No. 03853

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder Nursing Home				d. STREET ADDRESS 16			
3. NAME OF DECEASED (Type or print) First Edgar Middle L. Last Sheffer				4. DATE OF DEATH Month 3 Day 29 Year 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/1875	
9. AGE (In years last birthday) yrs 86		IF UNDER 1 YEAR Months 8 Days 29 Hours 19 Min 62		IF UNDER 24 HRS. Months 8 Days 29 Hours 19 Min 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) storekeeper				10b. KIND OF BUSINESS OR INDUSTRY general store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Sheffer				14. MOTHER'S MAIDEN NAME Amanda Shank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Everett Moser, Middletown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 45C IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema of left leg DUE TO (c) 3 days				INTERVAL BETWEEN ONSET AND DEATH 8 yrs 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 18, 1962 to March 29, 1962 , that I last saw the deceased alive on March 29, 1962 , and that death occurred at 8 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Van				ADDRESS (Street, city or town, state) Boonsboro		DATE SIGNED 3/29/62	
PHYSICIAN'S NAME (Type) G. W. H. Van				Ind			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/31/1962		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE APR 2 '62		24b. REGISTRAR'S SIGNATURE Clifford S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, or the registrar, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

03855

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u>		b. COUNTY <u>Washington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash County Hospital</u>		e. STREET ADDRESS <u>26 1/2 E. Franklin St</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH March 12 1962 19		Month		Day	
3. NAME OF DECEASED (Type or print) <u>OMAR HILL SMALL</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15 1894</u>		9. AGE (In years last birthday) <u>67 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Martinsburg Berkley Co Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Hill Small</u>		14. MOTHER'S MAIDEN NAME <u>Cora Day Riner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>317-05-7779</u>		17. INFORMANT <u>Wilburn M. Wade 2923 E. Monument St Baltimore Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> 141-7 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>cancer of tongue</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Beverly N. W. [Signature]</u>		22b. DATE SIGNED <u>MAR 15 '62</u>		22c. PHYSICIAN'S NAME (Type) <u>Andrew K. Coffman</u>		22d. ADDRESS <u>Hagerstown Wash Co Md.</u>		22e. REC'D BY REGISTRAR <u>William S. [Signature]</u>		22f. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/14/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>		23e. REC'D BY REGISTRAR <u>MAR 15 '62</u>		23f. REGISTRAR'S SIGNATURE	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

038860

038556

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>2101 Virginia Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Clora Sarah Smalts</u>		4. DATE OF DEATH <u>March 10 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28 1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. AGE (In years last birthday) <u>2</u> months <u>9</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hampshire County W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Noah Haines</u>		14. MOTHER'S MAIDEN NAME <u>Drusilla Oats</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Harry Smalts</u>		18. ADDRESS <u>2101 Virginia Ave. Hagerstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral embolus</u> DUE TO (b) <u>Auricular fibrillation</u> DUE TO (c) <u>3 mos.</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestion of Rt. Leg @ Paralysis</u>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-1962 to 3-10-1962 that (I) (we) last saw the deceased alive on 3-10-1962 and that death occurred at 3 M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Byrkit</u>		22b. DATE SIGNED <u>3-10-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 13-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Lee</u>		25a. REC'D BY REGISTRAR <u>MAR 14 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>W. L. Pinner</u>			

CERTIFICATE OF DEATH

03861

03857

1. PLACE OF DEATH
a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOONSBORO c. LENGTH OF STAY IN b. 10 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) REEDER NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 524 EAST FRANKLIN ST. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) FANNIE E. SMITH 4. DATE OF DEATH MARCH 6, 1962

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH MAY 6 - 1868 9. AGE (In years last birthday) 93 yrs 10 months 0 days 0 hours 0 min. IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME 11. BIRTHPLACE (County & State, or foreign country) SAMPLES MANOR WASH. Co. MD. 12. CITIZEN OF WHAT COUNTRY? NO RECORD

13. FATHER'S NAME ADRIAN SMITH 14. MOTHER'S MAIDEN NAME MRS. CLEMMIE BAKER BOONSBORO MD.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT MRS. CLEMMIE BAKER BOONSBORO MD. Address INTERVAL BETWEEN ONSET AND DEATH 24 hours

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to immediate cause (b) Severe arteriosclerosis
(c) due to
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Compensatory heart failure - Diabetic mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 2, 1962 to March 6, 1962 that (I) (we) last saw the deceased alive on March 5, 1962 and that death occurred 2:30 PM from the causes and on the date stated above.

22a. SIGNATURE Joseph Secundari M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI 22d. ADDRESS BOONSBORO MD

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF MARCH 9, 1962 23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY 23d. LOCATION (City, town or county) (State) BOONSBORO WASH. Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE John H. East ADDRESS BOONSBORO MD 25a. REQ'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Chas. L. Hanna DATE MAR 13 '62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. SECONDARI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03862

CERTIFICATE OF DEATH

03858

Item 7 Film G310 1/2/62 rh

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 1 Week		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 16 West Wilson Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MARY WORTHAM SMITH		4. DATE OF DEATH March 22 1962		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 7 1903		9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give most of work done during most of working life, even if retired) Tailor		11. BIRTHPLACE (County & State, or foreign country) Grayson County Ky.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E. E. Wortham		14. MOTHER'S MAIDEN NAME Ettie Carrier		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 520-16-1136		17. INFORMANT Mrs Myrtle Harmison 731 George St Hagerstown Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Ascites, abdominal, Auricular Fibrillation, Bundle Branch Block DUE TO 1 Hypertensive and Rheumatic Heart Disease DUE TO 2 unknown		INTERVAL BETWEEN ONSET AND DEATH 1. 1 1/2 yrs. 2. unknown							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year March 13 1962 Hour a.m. p.m. 10 am		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		20g. (County) Washington		20h. (State) Md.			
21. I certify that (I) (XXXXXX) attended the deceased from March 13 1962 to March 22 1962 that (I) last saw the deceased alive on Mar. 20 1962 and that death occurred at 10 am from the causes and on the date stated above.		22a. SIGNATURE W. J. Layman		22b. DATE SIGNED 3-23-62		22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 5 Public Square Hagerstown, Maryland		22e. REC'D BY REGISTRAR MAR 27 '62		22f. REGISTRAR'S SIGNATURE William T. Layman							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown Wash Co Md.		23e. (State) Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24b. ADDRESS Hagerstown Md.		24c. DATE MAR 27 '62		24d. REGISTRAR'S SIGNATURE William T. Layman													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03863

CERTIFICATE OF DEATH

03859

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 9 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLEAR SPRING d. STREET ADDRESS MAIN ST., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BESSIE GILMAN SNYDER 4. DATE OF DEATH MARCH 25 19 62		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH MARCH 24, 1894 9. AGE (in years last birthday) 68 yrs. IF UNDER 1 YEAR: Months 0 Days 1 IF UNDER 24 HRS.: Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER 10b. KIND OF BUSINESS OR INDUSTRY ELEMENTARY 11. BIRTHPLACE (County & State, or foreign country) INDIAN SPRINGS, MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANCIS P. HULL 14. MOTHER'S MAIDEN NAME ELIZEBETH STARLIPER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO 16. SOCIAL SECURITY NO. 219-36-3629 17. INFORMANT WILLIAM HULL 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION 4-20-1 Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE (c) 10 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CARCINOMA OF THE CERVIX WITH LOCALIZED METASTASIS 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year March 15, 1962 Hour a.m. 19 p.m. 12:40 PM 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town) Clear Spring, Maryland (County) (State)			
21. I certify that (I) (the doctor) attended the deceased from March 15, 1962 to March 25, 1962 , that (I) (we) last saw the deceased alive on March 25, 1962 , and that death occurred at 12:40 PM from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Archie Robert Cohen 22b. DATE SIGNED 03/27/62 22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. 22d. ADDRESS Clear Spring, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF MARCH 28, 1962 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY 23d. LOCATION (City, town or county) CLEAR SPRING, MD. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret Rowland 25. REGISTRAR'S SIGNATURE Arthur L. Kraus 26. DATE MAR 29 '62			

YR A15 (4)
15M 7/61



CERTIFICATE OF DEATH

03864

03860

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>Moller Apts</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HAZEL KINGSBERY STALEY</u>		4. DATE OF DEATH <u>March 6 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTH-PLACE (County & State, or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Warren W. Kingsbery</u>		14. MOTHER'S MAIDEN NAME <u>Etta Goering</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Louise Miller</u>		Address <u>Moller Apts</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uterine Fibroid</u> DUE TO <u>Arteriosclerotic heart disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>75 min</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January 1 1956</u> to <u>3/5</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>62</u> , and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Harrison</u>		22b. DATE SIGNED <u>3/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u>		22d. ADDRESS <u>318 N. Potomac St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/10/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Marks Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Lappans Cross Rd Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24b. ADDRESS <u>Hagerstown Md.</u>	
25a. REC'D BY REGISTRAR <u>WAG</u>		25b. REGISTRAR'S SIGNATURE <u>WAG</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

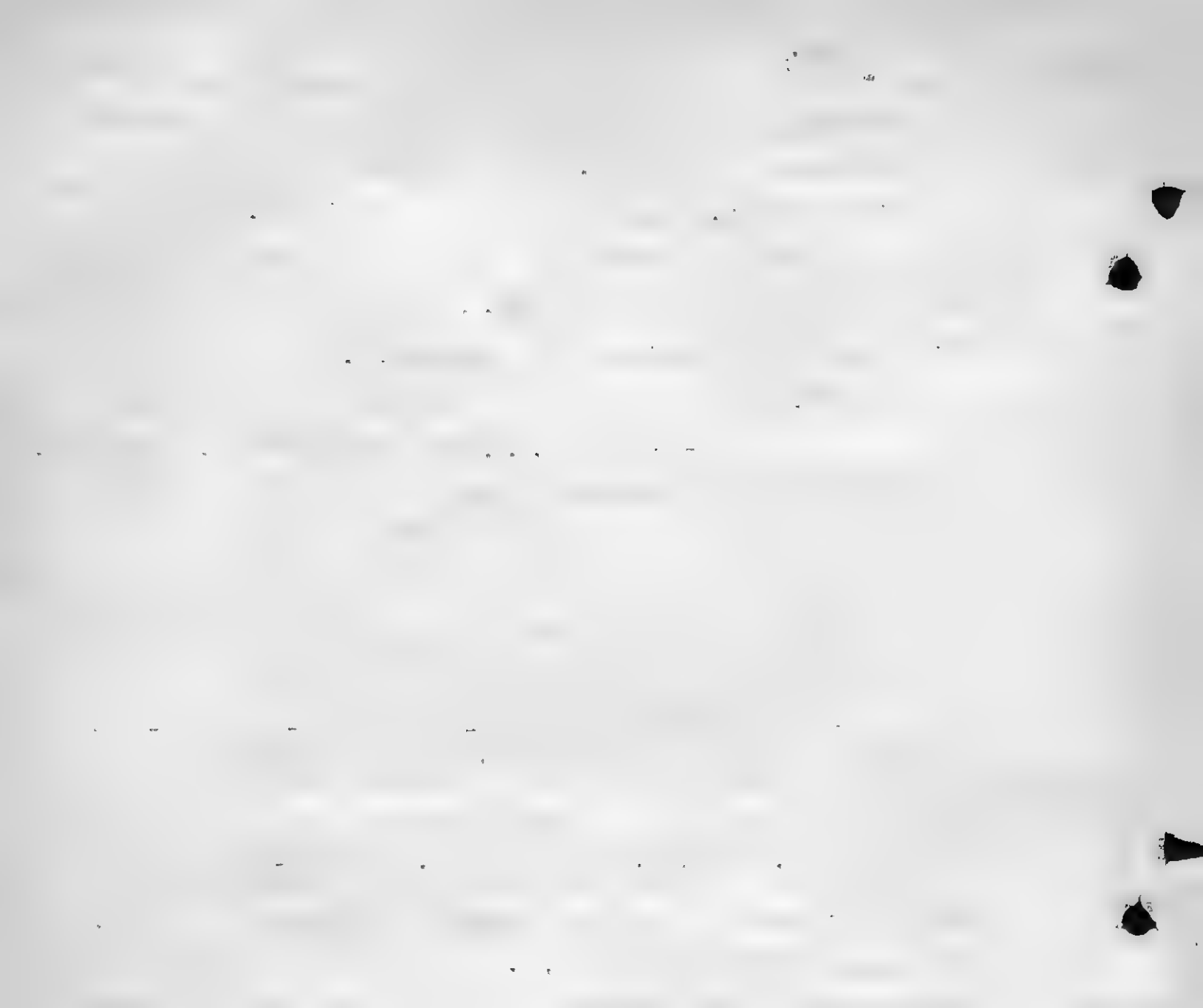
CERTIFICATE OF DEATH

03865

03861

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>40 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>722 Oak Hill Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> g. STREET ADDRESS <u>722 Oak Hill Ave.</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Donald</u> Last <u>Starr</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1906</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>John J. Starr</u>		16. MOTHER'S MAIDEN NAME <u>Emma Kalb</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		18. SOCIAL SECURITY NO. <u>705-10-5723</u>	
19. INFORMANT <u>Mrs. J. D. Starr</u>		Address <u>722 Oak Hill Ave. Hagerstown, Md.</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20-1</u> DUE TO <u>Cardiac Arrhythmia</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u>Acute myocardial Infarct</u> (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Conjunctive Heart Failure</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
22a. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		22b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		22d. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
23. I certify that (I) (this hospital) attended the deceased from <u>Feb. 12</u> , 19 <u>62</u> to <u>March 10</u> , 1962, that (I) (we) last saw the deceased alive on <u>March 8</u> , 19 <u>62</u> , and that death occurred at <u>10AM</u> , from the causes and on the date stated above.			
24a. SIGNATURE <u>Harold R. Tritch Jr.</u> M.D.		24b. DATE <u>3-12-62</u>	
24c. PHYSICIAN'S NAME (Type) <u>Harold R. Tritch, Jr. MD</u>		24d. ADDRESS <u>302 N. Potomac St. Hagerstown, Md</u>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		25b. DATE THEREOF <u>3/12/62</u>	
25c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		25d. LOCATION (City, town or county) <u>Hagerstown</u> (State) <u>Md.</u>	
25e. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25f. REC'D BY REGISTRAR <u> </u> 25g. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03866

03862

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY in lb <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clearspring</u> d. STREET ADDRESS <u>Clearspring Md RFD #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virgie</u> Middle <u>Mae</u> Last <u>Stevens</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1962</u>		5. SEX <u>Female</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 8 1903</u>		9. AGE (In years last birthday) <u>58</u> yrs IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Groceries</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Near Mercersburg Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>John J. Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Tosten</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-8128</u>		17. INFORMANT <u>Pinesburg Williamsport</u> <u>Mrs. Raymond Staley</u> <u>RFD #1 Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Chronic rheumatic heart disease</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 28, 1962</u> to <u>March 17, 1962</u> that (I) (we) last saw the deceased alive on <u>March 17, 1962</u> and that death occurred at <u>7:30 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. L. Packer Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>145 W. Washington St</u> <u>Hagerstown, Md</u>		22b. DATE SIGNED <u>3/19/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer Jr.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 20-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u> </u> <u> </u> DATE <u>MAR 20 '62</u>					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03867

CERTIFICATE OF DEATH

03863

1. PLACE OF DEATH
a. COUNTY Washington **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 15 8 wks.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Rt. #3
d. STREET ADDRESS St. James Village e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
HARVEY LEE STOTELMYER
4. DATE OF DEATH March 20 1962
Month Day Year

5. SEX Male **6. COLOR OR RACE** White **7. MARRIED** ☐ NEVER MARRIED ☐ **8. DATE OF BIRTH** January 8, 1870 **9. AGE** (In years last birthday) 92 yrs. **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Farmer **11. BIRTHPLACE** (County & State, or foreign country) Wolfesville, Fred. Co. Md. **12. CITIZEN OF WHAT COUNTRY?** USA.

13. FATHER'S NAME John Stotelmyer **14. MOTHER'S MAIDEN NAME** Jane Gruber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No **16. SOCIAL SECURITY NO.** None **17. INFORMANT** Edgar Stotelmyer, 1032 Rose Hill Ave. Address Hagerstown, Maryland.

18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 200.2 DUE TO Malignant Lymphoma
Conditions, if any, which gave rise to immediate cause (b) 1 yr.
(e), stating the underlying cause last. DUE TO (c) Secondary Chemia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **20b. DESCRIBE HOW INJURY OCCURED** (Enter nature of injury in Part I or Part I of item 18.)
20c. TIME OF INJURY Month, Day, Year March 20, 1962 **20d. INJURY OCCURRED** at work **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) at work **20f. (City or town)** Hagerstown **(County)** Washington **(State)** Md.

21. I certify that (I) (this hospital) attended the deceased from March 20, 1962 **to** March 20, 1962 **that (I) (we) last saw the deceased alive on** March 20, 1962 **and that death occurred at** March 20, 1962 **from the causes and on the date stated above**

22a. SIGNATURE J. H. Beachley **22b. DATE** March 21, 1962
22c. PHYSICIAN'S NAME (Type) J. H. Beachley **22d. ADDRESS** Hagerstown **22e. MED. DIRECTOR** ☐ **22f. STAFF PHYS.** ☐

23a. BURIAL, CREMATION REMOVAL (Specify) Burial **23b. DATE THEREOF** 3/23/62 **23c. NAME OF CEMETERY OR CREMATORY** Manor Cemetery **23d. LOCATION** (City, town, or county) Maryland. **(State)** near Tilghampton Wash. Co.

24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman **25a. REC'D BY REGISTRAR** Andrew K. Coffman **25b. REGISTRAR'S SIGNATURE** Andrew K. Coffman
Hagerstown, Maryland. **DATE** MAR 23 '62

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3868

03864

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN b 6 MOS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) AVALON MANOR CONVALESCENT HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 221 RIDGEMEDE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT ANNAN STOTT		4. DATE OF DEATH Month MARCH Day 25 Year 1962	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 14 1889	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL SUPPLY	
11. BIRTHPLACE (County & State, or foreign country) CARROLL MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWIN CHESTER STOTT		14. MOTHER'S MAIDEN NAME MARGARET GRAYSON GALT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW 1		16. SOCIAL SECURITY NO. 214-09-0015A	
17. INFORMANT MRS. ROBERT A STOTT		Address BALTIMORE MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sudden cardiac arrest - probable arrhythmia Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic heart disease (a), stating the underlying cause last, (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 0		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 23, 1962 to March 25, 1962 that (I) (we) last saw the deceased alive on March 23, 1962 and that death occurred at 6 AM , from the causes and on the date stated above.		22a. SIGNATURE John C. Stauffer M.D. 22b. DATE SIGNED MARCH 26 1962	
22c. PHYSICIAN'S NAME (Type) JOHN C. STAUFFER M.D.		22d. ADDRESS 145 S PROSPECT ST. HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-27-62	
23c. NAME OF CEMETERY OR CREMATORY PINEY CREEK CEMETERY		23d. LOCATION (City, town or county) (State) TANEYTOWN MARYLAND	
24. GENERAL DIRECTOR'S SIGNATURE Charles H. Meyer		25a. REC'D BY REGISTRAR DATE MAR 30 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2, which must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03869		03865	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lantz</u> c. LENGTH OF STAY (In months) <u>61 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lantz R.D.1</u> d. STREET ADDRESS <div style="text-align: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Stottlemeyer</u> Last <u>Stottlemeyer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 24, 1877</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, Md.</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Stottlemeyer</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hurley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Glen Stottlemeyer</u>		18. ADDRESS <u>Lantz, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompenstation, acute</u> <u>481X</u> DUE TO <u>Influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>12-24 hrs.</u> <u>2-4 wks.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 March 1962</u> to <u>4 March 1962</u> that (I) (we) last saw the deceased alive on <u>4 March 1962</u> and that death occurred at <u>8:30 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry H. Youngs Jr.</u>		22b. DATE SIGNED <u>3-6-62</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Strangs</u>		23d. LOCATION (City, town or county) (State) <u>Washington Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Greer</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>MAR 8 '62</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the attending physician and the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03870

03866

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if Institution's Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAN MAR		c. LENGTH OF STAY IN IT 6 1/2 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAHNEY-KEEDY MEMORIAL HOME		d. STREET ADDRESS NORTH MAIN ST.	
3. NAME OF DECEASED (Type or print) ALCYRUS HARRISON STOFFER		4. DATE OF DEATH MARCH 11 1962	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 27 1875 - 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYER		11. BIRTHPLACE (County & State, or foreign country) NEAR BOONSBORO WASH. CO. MD. U.S.A.	
13. FATHER'S NAME EDWARD STOFFER		14. MOTHER'S MAIDEN NAME LAURA GILGEOUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 212-14-6314	
17. INFORMANT MRS. CLARENCE FELTZ		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic glomerular nephritis, 1 year (b) Due to (c) Due to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis, 7 years	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... March 3, 1957, to March 9, 1962, that (I) (we) last saw the deceased alive on... 3-9-1962, and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph Secondary		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARY		22d. ADDRESS BOONSBORO MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 14 1962	
23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		23d. LOCATION (City, town or county) (State) BOONSBORO WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John T. East		25a. REC'D BY REGISTRAR DATE MAR 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03871

03867

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 48 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 651 Court Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ava Middle Blondell Last Swain		4. DATE OF DEATH Month March Day 22 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1899	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Luray, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Carl Kibler		14. MOTHER'S MAIDEN NAME Irene Ruffner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Marie Lorshbaugh Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 260X DUE TO Toxemia per - Hysteria of 15 1/2 hrs Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Died at home DUE TO Died at home		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs. Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour --- m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown (County) Washington (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1955 to 2244 1962 , that (I) (we) last saw the deceased alive on 27th 1962 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. D. WILSON, M.D.		22b. DATE SIGNED 3/23/62	
22c. PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.		22d. ADDRESS 135 N. TOMAC ST. HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown, Md. (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR MAR 27 '62	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Robert L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons of pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03872

CERTIFICATE OF DEATH

03868

1. PLACE OF DEATH e. COUNTY <u>WASHINGTON</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MARYLAND STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>LEAF'S ALLEY</u>	
3. NAME OF DECEASED (Type or print) <u>PAULINE FLORA THOMPSON</u>		4. DATE OF DEATH <u>MARCH 22 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 7 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTINSBURG W. VA</u>	
11. FATHER'S NAME <u>JOHN W MOORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		14. SOCIAL SECURITY NO. <u>NO ONE</u>	
15. INFORMANT <u>MRS PAULINE STEVENS</u>		16. ADDRESS <u>HAGERSTOWN MD</u>	
17. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Unknown</u> (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Osteoarthritis of spine</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-11-61</u> 19 <u>61</u> , to <u>3-22-62</u> 19 <u>62</u> that (I) <u>did</u> last saw the deceased alive on <u>3-22-62</u> 19 <u>62</u> and that death occurred at <u>8:15</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u> M.D.		22b. DATE SIGNED <u>3-22-1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Pa Ave Hagerstown MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-26-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Rouzer</u>		25a. REC'D BY REGISTRAR <u>SUTER-ROUZER FUNERAL HOME</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Thoma</u>		DATE <u>MAR 27 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03873
CERTIFICATE OF DEATH
03869

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b 4 MOS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 135 N CANNON AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 609 SUMMIT AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUISE JULIA THORNE		4. DATE OF DEATH Month MARCH Day 11 Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 29 1905
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CORSETIERE		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) HAGERSTOWN MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J EZRA MUSEY		14. MOTHER'S MAIDEN NAME CLARA B WEXX WHITE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-24-3693	
17. INFORMANT JEANNE M THORNE HAGERSTOWN MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor - Astrocytoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 8, 1961 to MARCH 11, 1962 that (I) (we) last saw the deceased alive on MAR 11, 1962 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman M.D.		22b. DATE SIGNED 3-12-62	
22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN M. D.		22d. ADDRESS 214 N POTOMAC ST. HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-14-62	
23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL GARDENS		23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Huns		25a. REC'D BY REGISTRAR APR 15 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Huns			

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03875

03871

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Yrs</u> c. LENGTH OF STAY IN b. <u>34 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Smithsburg-Beaver Creek Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 1</u> d. STREET ADDRESS <u>Smithsburg-Beaver Creek Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>EARNEST ELLSWORTH VANDERAU</u>				4. DATE OF DEATH <u>March 15 1962</u> <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 15 1883</u> <u>78</u> yrs.		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Adam Vanderau</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Phillipy</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> 16. SOCIAL SECURITY NO. <u>219-36-4822</u>			
17. INFORMANT <u>Mrs Ethel M. Shatzer Hagerstown Md. R #1</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death of Hemorrhage</u> (b) <u>331X</u> (c) <u>Arterio Sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>14 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9 days</u>			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)			
20h. (State)				21. I certify that (I) (th's hospital) attended the deceased from <u>Mar 15 1962</u> that (I) (we) last saw the deceased alive on <u>Mar 15 1962</u> and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G.A. Kohler</u> 22b. DATE SIGNED <u>Mar 17 1962</u>				22c. PHYSICIAN'S NAME (Type) <u>G.A. KOHLER</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/18/62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
23d. LOCATION (City, town or county) <u>Greencastle Franklin Co</u>				23e. (State) <u>Pa</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 20 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Chas E. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03876

03872

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>819 MEDWAY ROAD</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>819 MEDWAY RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARVIN L. WEBSTER</u> 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <u>MARCH 8, 1962</u> 9. AGE (In years last birthday) <u>45</u> yrs. <u>7</u> months <u>21</u> days 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>COAL CO.</u> 11. BIRTHPLACE (State or foreign country) <u>ROCKINGHAM CO. VA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REMUS WEBSTER</u> 14. MOTHER'S MAIDEN NAME <u>ANNIE</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>230-01-3169</u> 17. INFORMANT <u>MRS. ERSCEL WEBSTER</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> (b) <u>general arteriosclerosis and</u> (c) <u>arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval between onset and death 5-10 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4:20</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. DATE SIGNED <u>3/9/62</u> EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D.</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>MAR. 12, 1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>SAMPLES MANOR CEMETERY</u> 22d. LOCATION (City, town, or country) (State) <u>SAMPLES MANOR MD</u>		23. FUNERAL DIRECTOR <u>John H. Bast</u> Address <u>BOONSBORO MD</u> 24a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u> 24b. REGISTRAR'S SIGNATURE DATE <u>MAR 13 '62</u>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 of the funeral director's Office along with form PM3, Page 5 may be obtained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03877

03873

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN b. <u>49 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>815 THE TERRACE</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>815 THE TERRACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROGER</u> Middle <u>NMN</u> Last <u>WHIPPLE</u> b. SEX <u>MALE</u> c. COLOR OR RACE <u>WHITE</u> d. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> e. AGE (In years last birthday) <u>86 yrs.</u> f. UNDER 1 YEAR <input type="checkbox"/> g. UNDER 24 HRS. <input type="checkbox"/>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>19 62</u> 5. DATE OF BIRTH <u>FEBRUARY 14 1876</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE-PRESIDENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE COMPANY</u> 11. BIRTHPLACE (County & State, or foreign country) <u>SALEM MASS.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>STEPHEN L WHIPPLE</u> 14. MOTHER'S MAIDEN NAME <u>AUGUSTA TRUMBULL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>MRS. ROGER WHIPPLE HAGERSTOWN MARYLAND</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerosis - Generalized</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>4200</u> <u>2 Wks.</u> <u>2 yrs.</u> <u>10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)		20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>19</u> (County) <u>19</u> (State) <u>19</u>		21. I certify that (I) (Name of hospital) attended the deceased from.. Feb 28, 1962 to Mar 9, 1962, that (I) last saw the deceased alive on Mar 9, 1962 and that death occurred at 1:05 PM, from the causes and on the date stated above	
22a. SIGNATURE <u>Lloyd A. Hoffman</u> 22c. PHYSICIAN'S NAME (Type) <u>LLOYD A. HOFFMAN M. D.</u>		22b. DATE SIGNED <u>3-12-62</u> 22d. ADDRESS <u>214 N POTOMAC ST. HAGERSTOWN MARYLAND</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3-13-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL MAUSOLEUM</u> 23d. LOCATION (City, town or county) <u>HAGERSTOWN MARYLAND</u> (State) <u>MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Super-Houzer Funeral Home</u> 25a. REC'D BY REGISTRAR <u>15 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Chas. S. Kline</u>	

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